STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056444	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Extended Care Hospital of Montclair	9620 Fremont Avenue Montclair, CA 91763

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview and record review, the facility failed to respect the rights of one of the three sampled residents (Resident 1) when a Certified Nurse Assistant (CNA 1) turned on the light in Resident 1 ' s room without her permission on September 28, 2024. This failure had the potential compromise Resident 1 ' s sense of safety and dignity. Findings: During a review of Resident 1 ' s Admission Record (contains demographic and medical information) it indicated Resident 1, was initially admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure (the lungs can ' t get enough oxygen into the body), tracheostomy (a medical procedure where a small hole is made in the neck and windpipe to help someone breath), and dependence on respiratory. During a review of Resident 1 ' s Minimum Data Set (MDS), Section C Cognitive Patterns (items in this section are intended to determine the resident ' s attention, orientation and ability to register and recall new information.), dated September 26, 2024, it indicated Resident 1 had a Brief Interview for Mental Status (used to determine functioning used to determine a resident cognitive functioning status) Score of 14 (a core of 13-15 indicates intact cognition.) During a concurrent observation and interview, on October 9, 2024, at 2:14 PM, Resident 1, stated that CNA 1 entered her room, turned on the overhead light without asking for permission, and dismissed her concern about her medical condition. Resident 1, who was lying in bed with her head elevated to 45 - degree angle in a dimly lit room, expressed that her sensitivity to bright light made it uncomfortable for her when the light was turned on without her consent. During a phone interview on October 9, 2024, at 5:57 PM, with (CNA 1), CNA 1 confirmed that he turned on the light at Resident 1 ' s room without permission on September 29, 2024. CNA 1 acknowledged that he should have asked Resident 1 first to respect her preference. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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Community Extended Care Hospital of Montclair	9620 Fremont Avenue Montclair, CA 91763

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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 - Few	During a concurrent interview and record review on November 11, 2024, at 2:18 PM, with Director of Nursing (DON), the facility ' s policy and procedure (P&P) titled Resident Rights Policy, dated September 2017, was reviewed. The policy indicated Facility must protect promote their rights each resident .To be free from mental and physical abuse .Participate in the development and implementation of his on her person. centered plan of care to include establishing goals and outcomes and to be informed in advance of changes to be plan of care. Also, the right to identify individuals to be included in are planning, the right to request meetings or revisions to the care plan .To be treated with consideration, respect and full recognition of dignity and individually, including privacy in treatment and in care of personal needs. To resident and receive services with reasonable accommodation of resident need and preferences unless to do so would endanger the health and safety of the resident or other residents . The DON stated the staff did not follow the policy.

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Community Extended Care Hospital of Montclair	9620 Fremont Avenue Montclair, CA 91763

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47098 Based on observation, interview, and record review, the facility failed to implement the care for one of three sampled residents (Resident 1), who required two - person assistance for repositioning and care, when Certified Nursing Assistant (CNA 1) provided care to Resident 1 on two separate occasions (September 28, 2024, and September 29, 2024.) This failure has the potential to compromise Resident 1 ' s physical safety, emotional well-being and trust in care services. Findings: During a review of Resident 1 ' s Admission Record (contains demographic and medical information),it indicated Resident 1, was initially admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure (the lungs can ' t get enough oxygen into the body), tracheostomy (a medical procedure where a small hole is made in the neck and windpipe to help someone breath), and dependence on respiratory. During a review of Resident 1 ' s care plan titled ADL (Activities of Daily Living) Functional / Rehabilitation Potential, dated July 8, 2024, it indicated, impaired physical mobility and self - care r/t [related t0] scoliosis (when the spine curves sideways into an S or C) muscular dystrophy (a condition where the muscles in the body become weak and lose strength .roll left & right max of assistance (a person needs a lot of help from one or more caregivers to do basic), approach plan .provide 2 person assist . During a review of Resident 1 ' s Minimum Data Set (MDS), Section C Cognitive patterns (items in the section are intended to determine the resident ' s attention, orientation and ability to register and recall new information), dated September 26, 2024, it indicated Resident 1 had a Brief Interview for Mental Status (used to determine functioning use to determine a resident cognitive functioning status) Score of 14 (A score 13-15 indicates intact cognition.) During a review of Resident 1 ' s Minimum Data Set (MDS) Section GG functional Abilities and Goals, dated September 26, 2024, it indicted, Resident 1 was dependent (helps does all of the efforts, Resident does none of the efforts to complete the activity .or the assistance of two or more helper is required for resident to complete activity.) for toileting hygiene. During a concurrent observation and interview on October 9, 2024, at 2:14 PM, inside Resident 1 ' s room, Resident 1 was lying in bed with the head of the bed elevated to approximately 45 degrees. Resident 1 stated that over the weekend, CNA 1 provided care alone two occasions, despite her care plan requiring two-person assistance for repositioning and care. She further stated that this led to a commotion, prompting a Respiratory Therapist (RT) to enter the room and assist CAN 1. Resident 1 expressed frustration with CNA1 ' s action and reported feeling unsafe during these incidents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on October 9, 2024, at 5:57 PM, with CNA 1, CNA 1 stated first incident occurred on September 28, 2024.) CNA 1 stated he entered Resident 1 ' s room and attempted to change Resident 1 by himself. He further stated the situation escalated when Resident because upset, and a Respiratory Therapist (RT) overheard the commotion entered the room and assisted with the repositioning and care. CNA 1 stated he did not ask for help, and he was unaware of the two-person requirement. CNA 1 further stated the same incident occurred again on September 29, 2024. During a phone interview on October 10, 2024, at 9:23 AM, with Registered Nurse (RN 1), RN 1 states she did not informed CAN 1 of two - person assistance requirement for all residents in the subacute unit (a care area for patient who need require more medical support related to physical weakness or unable to help themselves and depend on medical equipment.) During a concurrent interview and record review on November 15, 2024, at 5:23 PM the facility ' s policy titled Care Planning - Interdisciplinary Team, dated January 2017, was reviewed. The policy indicated, The care plan is based on the resident ' s needs and the resident ' s comprehensive assessment and is developed by a Care Planning / Interdisciplinary Team .Nursing Assistants responsible for the resident ' s care .