

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056444	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Community Extended Care Hospital of Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Let each resident or the resident's legal representative access or purchase copies of all the resident's records.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47110</p> <p>Based on interview and record review, the facility failed to ensure a resident was able to exercise the right to access personal and medical records for one of three residents (Resident 1), when medical records for Resident 1 were requested by Resident 1 Power of Attorney (POA) but were not delivered within two working days of the request as per the facility ' s policy.</p> <p>This failure resulted in a violation of Resident 1 ' s right to have access to medical records as requested by POA.</p> <p>Findings:</p> <p>During a review of Resident 1 Face Sheet (Contain Resident 1 demographic), the Face Sheet indicated, Resident 1 was admitted on [DATE], with diagnosis that included cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain tissue to die).</p> <p>During an interview on May 7, 2025, at 11:40 AM, with the Medical Record Supervisor (MRS 1), the MRS 1 indicated that the POA for Resident 1 requested the resident's documents on Thursday, April 24, 2025, and completed the necessary release form on the same day. On April 30, 2025, she reached out to Resident 1's POA to notify her that the documents were ready for collection, which Resident 1 ' s POA did on that day. The MRS 1 acknowledged that the release of the documents exceeded the 48-hour policy, recognizing that they had gone beyond the specified timeframe. Nevertheless, she asserted that she followed the established protocol, which required the Director of Nursing and nursing staff to review the chart, followed by an administrative review of the documents before their release. She admitted that adherence to protocol does not justify the failure to comply with the timeline.</p> <p>During a review of document titled, Resident/Resident Representative Request for Access to Protected Health Information indicated Resident 1 POA requested Resident 1 Medical Record signed by POA on April 24, 2025.</p> <p>During an interview on May 7, 2025, at 12:31 PM, with the Director of Nursing (DON 1), the DON stated that passing the dateline in releasing resident ' s medical record to the family is unacceptable because family needs to look at the documentation and that is their right.</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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on May 14, at 2:47 PM, with MRS 1, MRS 1 reported that the POA of Resident 1 collected the medication record on April 30, 2025, made a cash payment for the documents, and received a receipt in return.</p> <p>During a review facility document titled, receipt (document containing payment confirmation), dated April 30, 2025, the receipt indicated payment receipt for Resident 1 records.</p> <p>During a review of facility policy and procedures (P&P) dated titled, Release of Records indicated, .Copies or any portion of them should be available within 2 working days of the request with advance notice to the facility .</p> <p>Based on interview and record review, the facility failed to ensure a resident was able to exercise the right to access personal and medical records for one of three residents (Resident 1), when medical records for Resident 1 were requested by Resident 1 Power of Attorney (POA) but were not delivered within two working days of the request as per the facility's policy.</p> <p>This failure resulted in a violation of Resident 1's right to have access to medical records as requested by POA.</p> <p>Findings:</p> <p>During a review of Resident 1 Face Sheet (Contain Resident 1 demographic), the Face Sheet indicated, Resident 1 was admitted on [DATE], with diagnosis that included cerebral infraction (a condition where blood flow to the brain is interrupted, causing brain tissue to die).</p> <p>During an interview on May 7, 2025, at 11:40 AM, with the Medical Record Supervisor (MRS 1), the MRS 1 indicated that the POA for Resident 1 requested the resident's documents on Thursday, April 24, 2025, and completed the necessary release form on the same day. On April 30, 2025, she reached out to Resident 1's POA to notify her that the documents were ready for collection, which Resident 1's POA did on that day. The MRS 1 acknowledged that the release of the documents exceeded the 48-hour policy, recognizing that they had gone beyond the specified timeframe. Nevertheless, she asserted that she followed the established protocol, which required the Director of Nursing and nursing staff to review the chart, followed by an administrative review of the documents before their release. She admitted that adherence to protocol does not justify the failure to comply with the timeline.</p> <p>During a review of document titled, Resident/Resident Representative Request for Access to Protected Health Information indicated Resident 1 POA requested Resident 1 Medical Record signed by POA on April 24, 2025.</p> <p>During an interview on May 7, 2025, at 12:31 PM, with the Director of Nursing (DON 1), the DON stated that passing the dateline in releasing resident's medical record to the family is unacceptable because family needs to look at the documentation and that is their right.</p> <p>During a telephone interview on May 14, at 2:47 PM, with MRS 1, MRS 1 reported that the POA of Resident 1 collected the medication record on April 30, 2025, made a cash payment for the documents, and received a receipt in return.</p> <p>(continued on next page)</p>		

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