

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 02/26/2026
NAME OF PROVIDER OR SUPPLIER Community Extended Care Hospital of Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 9620 Fremont Ave 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 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 its infection prevention and control program to prevent the transmission of infectious organisms when staff failed to properly maintain urinary catheter drainage systems and ensure resident care equipment was stored in a manner that prevented contamination.1. Urinary catheter drainage bags for four residents were observed resting on the floor, creating risk for contamination of the closed urinary drainage system.2. Resident care equipment (bedpans and urinals) in shared bathrooms were not labeled, creating potential for cross-use between residents. These failures created conditions conducive to the transmission of multidrug-resistant organisms and catheter-associated urinary tract infections and had the potential to place residents at risk for acquiring infections. Findings: 1. During a concurrent observation and interview on 2/24/26 at 10:26 a.m. with Certified Nursing Assistant (CNA) 2, Resident 5 was observed in bed with urinary catheter drainage bag touching the floor. CNA 2 confirmed Resident 5's urinary catheter drainage bag was on the floor. During a review of the Resident Demographics (Face Sheet), the Face Sheet indicated Resident 5 was admitted to the facility on [DATE] with diagnoses which included benign prostatic hyperplasia (noncancerous enlargement of the prostate gland). During a review of Resident 5's Physician's Orders, dated 2/2/26, the Physician's Orders indicated, Foley Catheter [indwelling tube inserted into the bladder to continuously drain urine into collection bag] every shift. During a concurrent observation and interview on 2/24/26 at 10:46 a.m. with CNA 3, Resident 47 was observed in bed with urinary catheter drainage bag positioned on the floor. CNA 3 confirmed Resident 47's urinary drainage bag was positioned on the floor. During a review of the Resident Demographics (Face Sheet), the Face Sheet indicated Resident 47 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder (loss of normal bladder control due to nerve damage). During a review of Resident 47's Physician's Orders, dated 9/24/25, the Physician's Orders indicated, Closed system Foley Catheter [indwelling tube inserted into the bladder to continuously drain urine into collection bag] for Neurogenic Bladder (condition where nerve damage disrupts bladder control.) During a concurrent observation and interview on 2/24/26 at 10:49 a.m. with CNA 3, Resident 130 was observed in bed with urinary catheter drainage bag positioned on the floor. CNA 3 confirmed Resident 130's urinary drainage bag was positioned on the floor. (continued on next page)		

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Resident Demographics (Face Sheet), the Face Sheet indicated Resident 130 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of the bladder (loss of normal bladder control due to nerve damage). During a review of Resident 130's Physician's Orders, dated 9/24/25, the Physician's Orders indicated, Foley Catheter [indwelling tube inserted into the bladder to continuously drain urine into collection bag] for neurogenic bladder (condition where nerve damage disrupts bladder control.) During an observation on 2/23/26 at 10:40 a.m. in Resident 52's room, the urinary drainage bag was observed touching the floor. During an interview on 2/24/26 at 11:00 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the urine drainage bag should not be touching the floor. During an interview on 2/25/26 at 1:43 p.m. with Infection Preventionist (IP), the IP stated that urinary catheter drainage bags should not touch the floor. IP further stated when urinary drainage bag or tubing touched the floor, contaminants could be introduced to the resident. During a review of the facility's policy and procedure (P&P) titled, Infection Control Program System, dated January 2023, the P&P indicated, The facility maintains written standards, policies and procedures for the infection control program, which includes. Standard and transmission-based precautions to be followed to prevent the spread of infection. 2. During a concurrent observation and interview on 2/24/26 at 10:57 a.m. with CNA 4, there was an unlabeled bedpan and unlabeled urinal in Resident 36's shared bathroom. CNA 4 confirmed the bedpan and the urinal were unlabeled and was unsure which resident the bedpan and urinal belonged to. During a concurrent observation and interview on 2/24/26 at 1:57 p.m. with CNA 5, unlabeled bedpan next to the toilet in Resident 3's shared bathroom. CNA 5 confirmed the bedpan next to the toilet was unlabeled and was unsure which resident the bedpan belonged to. During an interview on 2/25/26 at 1:43 p.m. with IP, the IP stated that bedpans and urinals should be labeled with resident's name and stored in the resident's designated closet. IP further stated that unlabeled bedpans and urinals left in the shared restroom could lead to cross contamination. During a review of the facility's P&P titled, Infection Control Program System, dated January 2023, the P&P indicated, The facility maintains written standards, policies and procedures for the infection control program, which includes. Standard and transmission-based precautions to be followed to prevent the spread of infection.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food items were stored and used within labeled use-by dates when one opened food container dated 2/20/26 was found in the walk-in refrigerator on 2/22/26. This failure had the potential for food borne illnesses for residents. Findings: During a concurrent observation and interview on 2/22/26 at 9:40 a.m. with Trayline Aide (TA) in the walk-in kitchen refrigerator, one opened salsa container was found labeled with a date of 2/13/26 and to be used by 2/20/26. TA stated that the container should not have been in the walk-in refrigerator and should have been removed for disposal. During an interview on 2/23/26 at 8:06 a.m. with Dietary Supervisor (DS), DS stated food items that were past the date on the label should not have been stored in the walk-in refrigerator. During an interview on 2/25/26 at 10:13 a.m. with Registered Dietician (RD), RD stated food that was past the date labeled in the walk-in refrigerator can be a threat to resident's safety. During a review of the facility's policy and procedure (P&P) titled, LEFTOVER FOODS, dated 2023, the P&P indicated, Leftover foods will be stored and served in a safe manner .		