STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555085	A. Building B. Wing	09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Manor Care Center	621 W Bonita Ave Claremont, CA 91711

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 45553 Based on interview and record review, the facility failed to report an allegation of physical abuse to the state agency (California Department of Public Health, CDPH) and law enforcement no later than two hours for one of seven sampled residents (Resident 2) and indicated in the facility's abuse prevention policy and procedure (P&P), titled, Adult Abuse,. This deficient practice resulted in the delay of notification to the state agency and had the potential for the residents residing at the facility to be subjected to further abuse. Cross Reference F610 Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 6/9/23 and readmitted Resident 2 on 6/16/23 with diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), muscle weakness (a lack of muscle strength), hypertensive heart disease (long standing elevated blood pressure), and acute diastolic heart failure (a sudden serious condition that occurs when the heart can't pump enough blood to meet the body's needs). During a review of Resident 2's History & Physical (H&P) dated 5/1/24, the H&P indicated Resident 2 can make needs known but cannot make medical decisions. During a review of the facility's Investigation Report (received from the facility on 9/26/24), date investigation commenced 9/13/24, the report indicated a complaint was received by the compliance department regarding Certified Nursing Assistant 1 (CNA 1) had squeezed Resident 2's brief around his genitalia (male or female reproductive organs) area to check if Resident 2's brief was wet while CNA 1 asked if Resident 2 needed to be changed. The report also indicated the facility was unable to substantiate the complaint regarding inappropriate touching by CNA 1. During an interview on 9/26/24 at 9:05 a.m., with the Administrator (ADM), the ADM stated a complaint was received through the facility's corporate compliance department (CCD) on 9/13/24. The ADM stated an investigation immediately began on 9/13/24 and the ADM reported the incident to CDPH, local police, and Ombudsman on 9/16/24. (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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NAME OF PROVIDER OR SUPPLIER Claremont Manor Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 621 W Bonita Ave 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Adult Abuse, revised date 7/2013, the P&P indicated, Reporting: For Physical Abuse: If the suspected abuse does not result in serious bodily injury, a telephone report shall be made to the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report (SOC 341) shall be made to the local ombudsman, the corresponding licensing agency, and the local law enforcement agency within 24 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse. The P&P indicated, If the suspected abuse results in serious bodily injury, a telephone report shall be made to the local law enforcement agency immediately, and no later than within 2 hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse, and a written report (SOC 341) shall be made to the local ombudsman, the Department of Public Health Licensing Division and the local law enforcement agency within two hours of the mandated reporter observing, obtaining knowledge of, or suspecting the physical abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45553 Based on interview and record review, the facility failed to immediately remove a potential threat for one of seven sampled residents (Resident 2). On 9/13/24, the facility received a report that indicated Certified Nursing Assistant 1 (CNA 1) squeezed Resident 2's brief around his genitalia (male or female reproductive organs) area to check if Resident 2's brief was wet. The facility failed to remove (CNA 1) from resident care duties and failed to make every attempt to prevent further potential abuse while the facility's investigation was in progress as indicated in the facility's abuse prevention policy and procedure (P&P), titled, Adult Abuse, . This deficient practice had the potential to result in further abuse for Resident 1 and for the residents residing at the facility. Cross Reference F609 Findings: During a review of Resident 2's Admission Record (AR), the AR indicated the facility originally admitted Resident 2 on 6/9/23 and readmitted Resident 2 on 6/16/23 with diagnoses including encephalopathy (a group of conditions that cause brain dysfunction), muscle weakness (a lack of muscle strength), hypertensive heart disease (long standing elevated blood pressure), and acute diastolic heart failure (a sudden serious condition that occurs when the heart can't pump enough blood to meet the body's needs). During a review of Resident 2's History & Physical (H&P) dated 5/1/24, the H&P indicated Resident 2 can make needs known but cannot make medical decisions. During a review of the facility's Investigation Report (received from the facility on 9/26/24), date investigation commenced 9/13/24, the report indicated a complaint was received by the compliance department regarding CNA 1 had squeezed Resident 2's brief around his genitalia area to check if Resident 2's brief was wet while CNA 1 asked if Resident 2 needed to be changed. The report also indicated the facility was unable to substantiate the complaint regarding inappropriate touching by CNA 1. During an interview with CNA 1 on 9/26/24 at 2:35 p.m., CNA 1 denied checking Resident 2's brief by touching or squeezing Resident 2 in the groin (area in the body where the upper thighs meet the lowest part of the abdomen) area. CNA 1 stated (regarding the incident with Resident 2), The administrator did not suspend me because they talked to the resident [Resident 2] and he denied that it happened. CNA 1 stated, I was able to continue my assignment. During an interview on 9/26/24 at 9:05 a.m., with the Administrator (ADM), the ADM stated a complaint was received through the facility's corporate compliance department (CCD) on 9/13/24 regarding CNA 1 inappropriately touching Resident 2. During a review of CNA 1's time sheets for 9/13/24 to 9/26/24, the time sheets indicated CNA 1 worked the following shifts: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 9/13/24 from 2:27 p.m. to 11 p.m. -On 9/14/24 from 2:27 p.m. to 11 p.m. -On 9/17/24 from 2:27 p.m. to 11 p.m. -On 9/18/24 from 2:27 p.m. to 11 p.m. -On 9/19/24 from 2:27 p.m. to 11 p.m. -On 9/20/24 from 2:27 p.m. to 11 p.m. -On 9/23/24 from 2:27 p.m. to 11 p.m. -On 9/24/24 from 2:27 p.m. to 11 p.m. -On 9/25/24 from 2:27 p.m. to 11 p.m. CNA 1's time sheets indicated CNA 1 was not suspended during the facility investigation, which started on 9/13/24. CNA 1 continued to work her regular schedule. During a review of the facility's P&P titled, Adult Abuse, revised date 7/2013, the P&P indicated, Policy: This community will enforce a non-tolerance of any form of behavior that might be construed as abuse by any individual, family member, staff member, visitor, volunteer, student or other person, including resident to resident abuse of any type. The P&P indicated, The facility will make every attempt to prevent further potential abuse while the investigation is in progress.