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	03/13/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's licensed staff failed to obtain informed consents (IC, the process, a form indicating a resident or responsible party voluntarily agrees to a medical treatment or procedure after understanding the risks, benefits, and alternatives) from two of two sampled resident's (Resident 35 and Resident 46) responsible parties by failing to:A. Obtain an IC from Resident 35 and/or the resident's responsible party prior to the administration of Mirtazapine 15 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount). Additionally, the facility failed to obtain an IC in a timely manner for the administration of Mirtazapine 30 mg when the dose was increased from 15 mg to 30 mg on 10/2/2025.B. Indicate the frequency (how often a drug should be given, times per day) for Mirtazapine (an antidepressant medication used mainly to treat major depression) 30 mg in Resident 35's IC dated 12/16/2025. C. Indicate in Resident 46's IC the reason for the use and benefits, probable side effects (SE, undesired harmful effect resulting from a medication) and significant risks of divalproex sodium (a medication used as a mood stabilizer) or the reasonable alternative modes of treatment including possible nonpharmacological (healthcare interventions that do not primarily rely on medications) approaches that could address Resident 46's needs.This deficient practice violated Resident 35's and Resident 46's right to be fully informed and to provide informed consents prior to the administration of psychotropic (group of drugs that change brain function: behavior, mood, thoughts, or perception, used to treat various mental health conditions) medications.Findings: A & B. During a review of Resident 35's admission Record (AR), the AR indicated the facility admitted Resident 35 on 6/16/2025, with diagnosis including, dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and chronic kidney disease (when the kidneys are damaged and gradually lose their ability to filter waste and extra fluid from the blood over a long period, usually months or years). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool), dated 12/23/2025, the MDS indicated Resident 35's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 35 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent on mobility. During a review of Resident 35's Order Recap Report (ORR), dated 3/12/2026, the ORR indicated Resident 35 had a prior order for Mirtazapine 15 mg with a start date of 06/27/2025 for depression manifested by poor PO intake, this order was discontinued on 10/2/2025. The ORR indicated an active order for Mirtazapine 30 mg with a start date of 10/2/2025, the active order indicated one tablet by mouth at bedtime for depression manifested by inability to sleep at night. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 35's Informed Consent Verification Form (ICVF), dated 12/16/2026, the ICVF's medication, dose, and frequency indicated Mirtazapine 30 mg PO (oral). The ICVF did not indicate the frequency for the administration of Mirtazapine. During a review of Resident 35's Medication Administration Record (MAR), dated June to December 2025 and dated January to March 2026, the MARs indicated the following: Resident 35 received Mirtazapine 15 mg from 6/27/2025 through 6/30/2025. Resident 35 received Mirtazapine 15 mg from 7/1/2025 through 7/31/2025. Resident 35 received Mirtazapine 15 mg from 8/01/2025 through 8/31/2025. Resident 35 received Mirtazapine 15 mg from 9/1/2025 through 9/30/2025. Resident 35 received Mirtazapine 15 mg on 10/1/2025. Resident 35 received Mirtazapine 30 mg from 10/2/2025 through 10/31/2026. Resident 35 received Mirtazapine 30 mg from 11/1/2025 through 11/30/2025. Resident 35 received Mirtazapine 30 mg from 12/1/2025 through 12/31/2025. Resident 35 received Mirtazapine 30 mg from 1/1/2026 through 1/31/2026. Resident 35 received Mirtazapine 30 mg from 2/1/2026 through 2/28/2026. Resident 35 received Mirtazapine 30 mg from 3/01/2026 through 3/12/2026 (date of review). During an interview and concurrent record review on 3/12/2026 at 11 AM, Resident 35's ICVF, ORR, and MARs were reviewed with Registered Nurse (RN) 1. RN 1 stated based on the ORR and MARs, Resident 35 was administered Mirtazapine 15 mg from 6/27/2025 through 10/01/2025. RN 1 stated no IC was obtained for the administration of Mirtazapine 15 mg, and no IC was found in Resident 35's medical record. RN 1 stated a new order for Mirtazapine 30 mg was started on 10/2/2025 and administered to Resident 35. RN 1 stated the ICVF indicated an IC for Mirtazapine 30 mg PO was obtained on 12/16/2025. RN 1 stated an IC was not obtained in a timely manner for Mirtazapine 130 mg. RN 1 stated an IC should have been obtained prior to the initial administration of Mirtazapine 15 mg and when the medication was first ordered on 6/27/2025. RN 1 stated a new IC should have been obtained on 10/02/2025 when the order for 15 mg was discontinued and the dose increased to 30 mg. RN 1 stated the ICVF did not include the frequency for Mirtazapine 30 mg and the IC was not completed. RN 1 stated antidepressants fell under the psychotropic medication classification and required ICs prior to administration [of these medications]. RN 1 stated the IC for Mirtazapine must have included the medication name, dosage, frequency, diagnosis, and associated behaviors/manifestations to ensure Resident 35 and/or the responsible party was fully informed of the treatment, including risks, benefits, and alternatives. RN 1 stated failure to obtain, and failure to complete ICs resulted in the resident and/or responsible party not being fully informed of the medication regimen, potentially impacting decision-making and the resident's rights. During an interview on 3/13/2026 at 10:45 AM, with the Director of Nursing (DON), the DON stated antidepressants fell under the psychotropic medication classification and required ICs prior to medication administration. The DON stated it was essential to obtain ICs prior to the administration of these medications to ensure residents (in general) and/or their responsible parties were fully informed of the medication, including the risks, benefits, alternatives, and intended use. The DON stated IC forms should be completed accurately and thoroughly, at a minimum including the medication name, dosage, frequency, and indication. The DON stated the information in the ICVF reflected the information provided to the resident and/or responsible party regarding treatment (administration of Mirtazapine). The DON further stated that incomplete or delayed informed consent created risk that treatment would be initiated without clear understanding or agreement, which could lead to confusion regarding the plan of care and undermine the resident's ability to make informed choices. During a review of the facility's Policy and Procedure (P&P) titled, Psychotherapeutic Medication Use, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	must verify that the resident or the resident's representative gave informed consent and make a notation in the resident's records.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have an effective medication reconciliation (systematic collection and verification of a resident's complete and accurate medications during transitions of care, aims to identify and resolve discrepancies and can result in preventable adverse drug events [SE, undesired harmful effect resulting from a medication] and helps to identify the loss or potential diversion [illegal distribution of prescription drugs or their use for unintended purposes] of controlled medications [medications with high potential for abuse]) system in place for controlled medications for 3 of 8 sampled residents (Resident 8, Resident 48, and Resident 49).This deficient practice resulted in unaccounted controlled medications for Resident 8, Resident 48, and Resident 49 and the potential for controlled medication diversion and misuse.Findings:During a review of Resident 8 admission Record (AR), the AR indicated the facility admitted Resident 8 on 4/19/2006 with diagnoses that included dementia (a progressive state of decline in mental abilities), adhesive capsulitis of the right shoulder (frozen shoulder causing stiffness and pain).During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 11/28/2025, the MDS indicated Resident 8's cognition (the ability to think and process information) was moderately impaired and Resident 8 had impaired range of motion (ROM, how far a person can move a joint or muscle in various directions) on the bilateral (both sides) upper and lower extremities (arms and legs). During a review of Resident 48's AR, the AR indicated the facility admitted Resident 48 on 12/23/2024 with diagnoses that included dementia, wedge compression fracture of the fourth lumbar vertebra (a fracture [broken bone] that usually occurs in front of the vertebra, collapsing the bone in the front of the spine).During a review of Resident 48's MDS dated [DATE], the MDS indicated Resident 48 had a short-term memory problem and moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 48 was dependent with all activities of daily living (ADL).During a review of Resident 49's AR, the AR indicated the facility admitted Resident 49 on 9/19/2018, with diagnoses that included dementia and malignant neoplasm of the breast (breast cancer).During a review of Resident 49's MDS, dated [DATE], the MDS indicated Resident 49's cognition was moderately impaired. The MDS indicated Resident 49's range of motion, upper extremities had no impairment and Resident 49 had impairment on one lower extremity.During a concurrent review of Resident 8's Narcotic Record (NR), issue date 7/28/2025, and review of the Medication Administration Record (MAR), dated 7/2025, the NR indicated Lorazepam (medication used to treat anxiety [intense, excessive, and persistent worry and fear about everyday situations], insomnia [sleep disorder], seizures [sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness], and other conditions by calming the central nervous system) 1 milligram (mg, unit of measurement) was removed from the narcotic supply for administration on 7/28/2025. The MAR indicated Lorazepam 1mg, give 1 tablet by mouth every 8 hours as needed for anxiety manifested as unconsolable yelling out. The MAR indicated on 7/28/2025 the space representing the dose for Lorazepam 1 mg was not signed-marked as administered.During a concurrent review of Resident 48's NR, issue date 12/10/2025, and review of the MAR, dated 12/2025, the NR indicated 1 tablet of acetaminophen with codeine (medication used to treat mild to moderate pain) 300 - 30 mg was removed from the narcotic supply for administration on 12/15/2025. The MAR indicated 1 tablet acetaminophen with codeine 300 - 30 mg by mouth every 6 hours as needed for mild to moderate pain. The MAR indicated on 12/15/2025 the space representing the dose for acetaminophen with codeine 300 - 30 mg was not signed-marked as administered.During a concurrent review of Resident 49's NR, issue date 12/10/2025, and review of the MAR, dated 12/2025, the NR indicated alprazolam (medication used for short term relief of moderate to severe anxiety disorders, panic disorders, and anxiety associated with depression) 0.25 mg tablet was (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed from narcotic supply for administration on 12/12/2025. The MAR indicated 1 tablet of 0.25 mg alprazolam by mouth every 8 hours as needed for anxiety manifested by inconsolable yelling. The MAR indicated on 12/12/2025 the space representing the dose for alprazolam 0.25 mg was not signed-marked as administered.During a review of Resident 8, Resident 48, and Resident 49's NRs and MARs and concurrent interview on 3/13/2026 at 12:26 PM with the Director of Nursing (DON), the DON was made aware 3 controlled medications were pulled out (documented on the NRs) and not marked as administered on the MARs for Residents 8, 48, and 49. The DON stated the facility did not have a system in place where the MARs were reconciled with the NRs. The DON stated the DON had not investigated the controlled medications that were not accounted for Residents 8, 48, and 49.During an interview on 3/13/2026 at 1:26 PM, with Licensed Vocational Nurse (LVN) 3, LVN 3 stated LVN 3 remembered Resident 48 needed pain medication for chronic (long standing) back pain but LVN 3 could not recall the reason why LVN 3 did not mark the acetaminophen with codeine as completed on the MAR. LVN 3 stated it was hard to recall the month of December 2025 to remember if the acetaminophen with codeine removed from the narcotic supply was administered to Resident 48.During a telephone interview on 3/13/2026 at 1:41 PM, LVN 4 stated LVN 4 remembered Resident 49 needed Alprazolam for constantly yelling behavior but LVN 4 could not recall the reason why LVN 4 did not mark alprazolam, recorded as removed on the narcotic record, as administered on the MAR.During an interview on 3/13/2026 at 2:12 PM, the DON stated signing [marking] the MARs indicated residents received the medications [removed from the NR]. The DON stated the process for administration of controlled medications included licensed nurses taking out the medication, signing [the removal] the NR and signing the MAR once the medication was administered to the resident. The DON stated the shift-to-shift reconciliation of controlled medications involved the licensed nurses to reconcile the medications signed out on the NR and the physical count of the medications.During a review of the facility's policy and procedure (P&P), dated 11/2017, titled Controlled Substances, the P&P indicated the DON and the Consultant Pharmacist establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The P&P indicated controlled medications are obtained from the locked cabinet or safe, or medication cart. The P&P indicated when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing the dose from controlled storage: date and time of administration, amount administered, and signature of the nurse administering the dose. The P&P indicated to administer the controlled medication and document the dose administration on the MAR. The P&P indicated when a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It must be destroyed according to policy and the disposal documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an advanced directive acknowledgement form (ADAF) for one of three sampled residents (Resident 1) as indicated in the facility's policy and procedure (P&P) titled, Advance Directives.This deficient practice had the potential to result in lack of knowledge regarding care and treatment decision making for Residents 1. Additionally, there was a potential to result in confusion among the healthcare providers in the event Residents 1 required immediate medical care and/treatment and the potential for Resident 1 to receive inadequate or medically unnecessary care and/or treatment or services regarding life-sustaining treatment.Findings:During a review of Resident 1's admission Record (AR), the AR, indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including osteoarthritis (a degenerative joint disease in which the tissues in the joint break down over time) and macular degeneration (eye disease that can blue your central vision.)During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 1 had intact cognition (ability to understand and process information) and was dependent (helper does all the effort) on staff for toileting and required substantial/ max assistance (helper does more than half the effort) for bathing.During a concurrent interview and record review on 3/12/2026 at 10 AM with Licensed Vocational Nurse (LVN) 3, Resident 1's medical record was reviewed. LVN 3 stated LVN 3 could not find Resident 1's ADAF in Resident 1's electronic medical record chart or in the physical medical record.During an interview on 3/12/2026 at 10:43 AM with the Social Services Director (SSD), the SSD stated the SSD could not find Resident 1's ADAF. The SSD stated the ADAF was important to ensure the facility knew who to give information to in the event Resident 1 was unable and to follow Resident 1's wishes for treatment including the code status (a medical order indicating a patient's preference for life-saving interventions).During a review of the facility's P&P titled, Advance Directives, dated 3/2024 the P&P's definition for advance directive indicated an advance directive is a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions because of a serious illness or injury. The P&P indicated upon admission to the community social services staff or designee will inform and provide written information to the resident concerning their right to formulate an advance directive. The P&P indicated an Acknowledgement for Advance Directive form will be completed, signed, and placed in the resident's medical record.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility staff failed to notify Physician 1 and the responsible party of a change of condition (COC, an alteration in a resident's physical health that differs from their previous baseline) for one of one sampled resident (Resident 17) when Resident 17 experienced a significant weight loss of 12 pounds (lbs., a unit of weight) within one week. This deficient practice had the potential to result in delated implementation of timely interventions and the potential to result in a physical decline to Resident 17.Findings:During a review of Resident 17's admission Record (AR), the AR indicated the facility admitted Resident 17 on 11/25/2025, and re-admitted the resident on 2/21/2026, with diagnosis including, chronic kidney disease (when the kidneys are damaged and gradually lose their ability to filter waste and extra fluid from the blood over a long period, usually months or years), acute kidney failure (the sudden and rapid loss of kidney function, typically occurring within a few days or hours), and urinary tract infection (UTI-an infection in the bladder/urinary tract)During a review of Resident 17's Minimum Data Set (MDS- a resident assessment tool), dated 2/28/2026, the MDS indicated Resident 17's cognition (the ability to think and process information) was severely impaired. The MDS indicated Resident 17 required partial/moderate assistance (helper does less than half effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required substantial/maximal assistance (helper does more than half the effort) with mobility.During a review of Resident 17's Order Summary Report (OSR), dated active as of 3/12/26, the OSR indicated an order, dated 2/21/2026, indicating to obtain weights weekly on Sundays for a duration of four (4) weeks for weight management.During a review of Resident 17's Weights and Vitals Summary (WVS), dated 3/13/2026, the WVS indicated,On 3/1/2026, Resident 17 weighed 169 lbs. (Sitting)On 3/9/2026, Resident 17 weighed 157 lbs. (Sitting).During a review of Resident 17's Medication Administration Record (MAR), dated March 2026, the MAR indicated:Resident 17 was administered Lasix (a medication [diuretic] used to remove excess fluid) 20 milligrams (mg-metric unit of measurement, used for medication dosage and/or amount), administered by mouth at bedtime (9 PM) for edema (swelling caused by excess fluid trapped in the body's tissues), with a start date of 3/3/2026 and an end date of 3/9/2026.Resident 17 received Lasix 40 mg, administered by mouth in the morning (9 AM) for lower extremity edema, with a start date of 03/4/2026 and an end date of 03/9/2026.During an interview and concurrent record review on 3/12/2026 at 11 AM, Resident 17's WVS and MAR were reviewed with Registered Nurse (RN) 1. RN 1 stated based on the WVS Resident 17 experienced a weight loss of 12 lbs. within one week. RN 1 stated the MAR indicated Resident 17 received Lasix for lower extremity edema during that same period. RN 1 stated this was significant weight loss and stated the decrease in weight was expected due to the therapeutic effect of diuresis (the body's process of making and passing more urine than usual) in managing the resident's fluid overload. RN 1 stated based on clinical judgment, a COC assessment (includes physician and responsible party notification) was not completed because the weight loss aligned with the intended treatment outcome. RN 1 stated Physician 1 (Resident 17's physician) and responsible party should have been notified of the significant weight change. RN 1 stated physician notification was essential to evaluate the resident's (in general) ongoing treatment plan, including determining whether to continue, adjust, or hold diuretic therapy, assess for potential complications such as dehydration or electrolyte imbalance, and determining if additional monitoring or laboratory testing was necessary. RN 1 stated notification of the responsible party was necessary to ensure they were informed of significant clinical changes impacting the resident's condition. RN 1 stated there was no documented evidence in Resident 17's medical record indicating Physician 1 or Resident 17's responsible party were notified. RN 1 stated standard nursing practice required that all communication [regarding Resident 17] be documented, and if it was not documented, it could not be verified as completed. RN 1 emphasized (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that accurate and timely communication with Physician 1 was necessary to reflect care provided and clinical decision-making.During an interview on 3/13/2026 at 10:45 AM, with the Director of Nursing (DON), the DON stated that in situations where a resident was undergoing diuretic therapy for fluid overload, a significant weight reduction may be anticipated as part of the treatment response, and a formal COC assessment may not always be required when the outcome is consistent with the care plan. The DON stated that significant weight changes, regardless of the cause, should be communicated to the physician (in general) to allow for ongoing clinical evaluation of the resident's status, including reassessment of medication effectiveness, risk for adverse effects (AE, undesired harmful effect resulting from a medication), and the need for further interventions or monitoring. The DON stated that notifying the responsible party was essential to maintain transparency and ensure they were aware of meaningful changes in the resident's health condition. The DON stated communication of these changes was critical and the medical record must clearly indicate the communication occurred. The DON stated that the absence of documentation created uncertainty and did not support continuity of care.During a review of the facility's policy and procedure (P&P) titled, Change in Resident Condition, revision dated 2/2009, the P&P indicated changes in resident condition will be communicated to the physician and responsible party timely. The P&P's routine Medical Change indicated document resident change of condition and response in the nursing progress notes, on 24-Hour report and update the resident care plan as indicated. The P&P indicated all attempts to reach the physician and responsible party will be documented in the nursing progress notes and the documentation will include the time and response.

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Claremont Manor Care Center	621 W Bonita Ave Claremont, CA 91711

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide transfer and bed-hold notification documentation for one of one sampled resident (Resident 42) as indicated in the facility's Policy and Procedure (P&P) titled, Admission, Transfer, & Discharge Rules, when:Resident 42 did not receive a written notice of transfer-discharge (a document a nursing facility must give a resident and/or their representative before the resident is moved out of the facility, explaining why the resident is being transferred, where they are going, the effective date, their right to appeal, and how to contact the State Long^Term Care Ombudsman [an advocate who helps protect the rights, safety, and well-being of residents in nursing homes and other long-term care facilities]) when Resident 42 was discharged on 2/15/2026.Resident 42 was not provided bed hold notification (a written notice a nursing facility gives a resident and/or their representative when the resident is sent to the hospital or leaves the facility, explaining whether the resident's bed will be held, for how long, and their right to return to that bed) upon Resident 42's discharge on [DATE].This failure had the potential to result in Resident 42 being uninformed of the right to appeal the hospital transfer and the right to return to the facility and had the potential to result in the State Long-Term Care Ombudsman being uninformed of Resident 42's hospital transfer.Findings:During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted Resident 42 on 1/30/2026 with diagnoses including encounter for surgical aftercare following surgery on the digestive system (a medical visit where a patient is being seen to monitor healing, manage recovery, or address follow^up needs after having surgery on any part of the digestive tract) and unspecified intestinal obstruction (a blockage in the intestines that prevents food, fluids, or gas from moving normally).During a review of Resident 42's Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 42's cognitive (the ability to think and process information) skills for daily decision making were intact. The MDS indicated Resident 42 required set up or clean-up assistance with eating, supervision or touching assistance with oral hygiene, partial to moderate assistance with personal hygiene, and was dependent on toileting, showering, and dressing.During a review of Resident 42's Physician Discharge Summary, discharge date [DATE], the Discharge Summary indicated Resident 42 was discharged to the General Acute Care Hospital (GACH) 1 on 2/15/2026.During a review of Resident 42's admission Notification of Bed-Hold Option, dated 2/4/2026, the Bed Hold Notification indicated, To Be Completed Upon Transfer [discharge] was not completed and left blank.During a concurrent interview and record review on 3/11/2026 at 2:57 PM with Licensed Vocational Nurse (LVN) 1, Resident 42's medical record was reviewed. LVN 1 stated LVN 1 discharged Resident 42 on 2/15/2026 but did not complete a notice of proposed transfer or discharge. Additionally, LVN 1 stated Resident 42's medical record did not contain documentation indicating Resident 42 received a bed hold notification upon discharge. LVN 1 stated it was important to fill out the notice of proposed transfer because it was Resident 42's right to be informed and to have the ombudsman informed of Resident 42's transfer. LVN 1 stated it was important to inform (offer) Resident 42 of the bed hold because this ensured Resident 42 was aware of the right to return to the facility if Resident 42 desired.During an interview on 3/12/2026 at 2:43 PM with the Director of Nursing (DON), the DON stated Resident 42's medical record did not indicate Resident 42 or the ombudsman received a notice of proposed transfer-discharge. The DON stated it was important to give Resident 42 a notice of proposed transfer-discharge because it ensured the resident was informed of why Resident 42 was being discharged and [made Resident 42 aware of] the right to appeal the transfer-discharge process. Additionally, the DON stated Resident 42's medical record did not indicate Resident 42 received [was offered] a bed hold notification. The DON stated it was important to inform Resident 42 of the bed-hold to ensure Resident 42 was informed of the right to return to the facility.During a review of the facility's P&P titled, Admission, (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Transfer, & Discharge Rules, dated January 2018, the P&P's policy indicated the facility did not discriminate when making admission, transfer, and discharge decisions and would follow identical policies and practices for all residents regardless of their source of payment when providing services that are required to be provided under the law. The P&P's admission, transfer and discharge rules indicated before the transfer or discharge occurred, the facility would notify the resident and, if known, the resident's representative of the transfer, the reasons for the transfer, and record the reasons in the medical record. The facility's notice would include an explanation of the right to appeal the transfer to the State, how to obtain an appeal form and how to obtain assistance with completing the form, and the facility's notice would be sent to the State Long-Term Care Ombudsman. Additionally, the P&P's admission, transfer, and discharge rules indicated whenever a resident was transferred to a hospital the facility had to provide a second written notice to the resident of the seven-day bed hold policy which included the policy on permitting the resident to return.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow pressure ulcer-injuries (PIs, lesion/wound caused by unrelieved pressure that results in damage of underlying tissue) preventive interventions for one of one sampled resident (Resident 15) by failing to:Encourage and offer to turn and reposition Resident 15 who preferred lying in bed on Resident 15's back.Float (healthcare practice aimed at preventing PIs by suspending the heels off the bed surface, thereby reducing pressure and friction on the skin) Resident 15's heels when Resident 15 was lying in bed.Ensure Resident 15's low air loss mattress (LAL, mattress that operates using a blower-based pump that was designed to circulate a constant flow of air) was set at the appropriate setting per the physician's order and not set on static (holds all air cells at the same inflation level, providing a stable, firm, and evenly distributed support surface for the resident) mode.This deficient practice had the potential to result in the development of new PIs to Resident 15. Findings:During a review of Resident 15's admission Record (AR), the AR indicated Resident 15 was originally admitted to the facility 3/30/2022 and readmitted on [DATE]. The AR indicated Resident 15's diagnoses included heart disease with heart failure and arthritis (group of conditions that cause joint inflammation, pain, stiffness, and swelling affecting movement and quality of life).During a review of Resident 15's care plan (CP), initiated 1/17/2025, the CP indicated Resident 15 had potential for PI development related to decreased mobility and history of ulcers. The CPs interventions indicated alternating pressure mattress for skin integrity, to assist/encourage to turn/reposition every 2 hours as tolerated, more often as needed or requested, and to float heels.During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 15's cognition (the ability to think and process information) was intact.During a review of Resident 15's CP, revised 1/16/2026, the CP indicated Resident 15 was at risk for skin breakdown related to fragile skin/ right lateral leg trauma wound. The CP's interventions indicated assisting [Resident 15] with repositioning frequently for pressure prevention and resident comfort and to float heels while in bed.During a review of Resident 15's Braden Scale - for Predicting Pressure Ulcer Risk Evaluation, dated 1/16/2026, the evaluation indicated Resident 15's activity was bedfast and Resident 15 was confined to a bed. The evaluation indicated Resident 15's mobility was very limited. The evaluation's friction and shear indicated, problem: requires moderate to maximum assistance in moving. The evaluation indicated a total score of 12 or less represented a high risk for PI development.During a review of Resident 15's Braden Scale - Assessment Outcomes, dated 1/16/2026, the assessment indicated Resident 15's score was 13 and Resident 15 was at high risk for PI development.During a review of Resident 15's Order Recap Report (ORR), dated March 2026, the ORR indicated a physician's order indicating Resident 15 may have an alternating pressure mattress for skin integrity, dated 3/5/2026.During an observation and concurrent interview on 3/10/2026 at 11:06 AM with Licensed Vocational Nurse (LVN) 1. Resident 15's LAL mattress setting was in static mode. LVN 1 stated static mode needed to be on for Resident 15.During an observation on 3/11/2026 at 9:36 AM with LVN 1, LVN 1 applied a lidocaine patch (topical medication that numbs a specific area of the skin to relieve pain), Resident 15 turned and LVN 1 applied the patch on Resident 15's lower back. After the patch was applied, Resident 15 laid on Resident 15's back. There was a pillow lengthwise under Resident 15's right leg, the pillow was touching Resident 15's right heel and the heel was not floating.During a continuous observation on 3/11/2026 from 9:36 AM to 1:21 PM, Resident 15 was lying on resident 15's back, the following observations were conducted,At 10:47 AM, a housekeeping (unidentified) staff entered Resident 15's room and Resident 15's heels were on top of a pillow.At 11 AM, Certified Nursing Assistant 4 (CNA 4) entered Resident 15's room to answer Resident 15's roommate's call light, Resident 15's heels were on top of a pillow. CNA 4 did not offer to turn or reposition Resident 15.At 11:02 AM, Resident 15's heels were on top of a pillow.At 12:20 PM, Resident 15 was sleeping (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and laying on Resident 15' back. Resident 15's heels were positioned directly on top of a pillow.At 12:29 PM, Resident 15 was eating lunch and sitting up in bed and Resident 15's heels were on top of a pillow.At 12:45 PM, CNA 4 entered Resident 15's room and took Resident 15's lunch tray, Resident 15's heels were on top of a pillow. CNA 4 did not offer to turn or reposition Resident 15.During a concurrent observation and interview 3/11/2026 at 1:21 PM with the Minimum Data Set Nurse (MDS). Resident 15 was laying on Resident 15's bed on Resident 15's back. The MDS stated Resident 15's heels were not floating and Resident 15's heels had to be floating.During a concurrent interview and record review on 3/11/2026 at 1:35 PM, LVN 1 stated, during the lidocaine patch administration, LVN 1 did not offer to turn or reposition Resident 15 and LVN 1 did not float Resident 15's heels. During a review of Resident 15's Order Recap Report, dated March 2026 with LVN 1, the physician orders indicated an order for alternating pressure mattress for skin integrity. LVN 1 stated Resident 15's LAL static mode needed to be changed to alternating pressure (a system that uses air filled cells that inflate and deflate in a cyclical pattern and helps to prevent prolonged pressure on a single area of the body, reducing the risk of damage. The system is designed to shift pressure points throughout the day, ensuring that no single area of the body experiences uninterrupted pressure, helping maintain adequate blood flow and preventing the development of PIs).During an interview on 3/11/2026 at 1:50 PM, Resident 15 stated Resident 15 agreed to be turned and repositioned by staff.During an interview on 3/13/2026 at 10:59 AM, with CNA 4, CNA 4 stated CNA 4 was assigned to care for Resident 15 and CNA 4 turned and repositioned Resident 15 on 3/11/2026 at around 9 AM. CNA 4 stated CNA 4 did not turn or reposition Resident 15 every 2 hours on 3/11/2026 because there was another resident (unidentified) who was restless and anxious that day and CNA 4 was busy with that resident. During a review of the facility's Policy and Procedure titled Skin Care Preventative Methods dated May 2016, the P&P indicated residents assessed to be at risk for skin impairment will have preventative measures placed into effect as appropriate for the resident to prevent skin breakdown. The P&P indicated intervention guidelines included the following: repositioning [while] in bed, turning and reposition residents every 2 hours or less depending on resident needs, use of pillows and cushions to distribute pressure, floating the heels for those with decreased sensation, hip and knee replacement(s).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow fall prevention interventions for one of two sampled residents (Resident 23) when on 3/12/2026, Resident 23 did not have bilateral fall mats (a specialized, thick cushion designed to be placed alongside a bed or chair to absorb the impact of falls and reduce the risk of serious injuries like fractures or head trauma) on the ground alongside Resident 23's bed and while Resident 23 was in bed.This deficient practice had the potential to result in falls and injury to Resident 23. Findings: During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including bilateral primary osteoarthritis of the knee (a long standing, degenerative disease where the protective cartilage in the knee joint gradually breaks down over time), restless leg syndrome (condition that causes a very strong urge to move the legs) and age-related osteoporosis (bone disease where bones become thin, brittle, fragile due to accelerated loss of density over time, making them highly susceptible to fractures).During a review of Resident 23's Minimum Data Set (MDS- a resident assessment tool), dated 10/6/2025, the MDS indicated Resident 23's cognition (ability to understand and process information) was moderately impaired and required substantial/ maximal assistance (helper does more than half the effort) for toileting and personal hygiene.During a review of Resident 23's Fall Risk Evaluation (FRE), dated 1/6/2026, the FRE indicated if the total score is 10 or greater, the resident should be considered at high risk for potential falls.During a review of Resident 23's Progress Notes (PN) dated 1/6/2026, timed at 11:09 AM, the PN indicated Resident 23 had intermittent confusion and had a fall risk score of 11.During a review of Resident 23's Care Plan (CP), initiated 1/7/2026, the CP's focus indicated Resident 23 was at risk for falls related to history of falls, impaired mobility, urinary incontinence (loss of bladder control), cognitive impairment with poor safety awareness such as taking self to the bathroom without calling for help. The CP indicated Resident 23 had an unwitnessed fall from bed transferring self without staff assistance on 2/5/2025 and had an unwitnessed fall on 1/7/2026. The CP's goal indicated for Resident 23 to not have injury related to falls over the next quarter with target date 4/25/2026. The CP's interventions indicated floor mat[s] on [the] sides of [the] bed to prevent injury from falls.During a concurrent observation and interview on 3/12/2026 at 3:45 PM in Resident 23's room with Licensed Vocational Nurse (LVN) 4, Resident 23's floor mats were observed propped up on the wall while Resident 23 was lying in bed. LVN 4 stated Resident 23 needed the fall mats on the ground while Resident 23 was in bed because Resident 23 got up unassisted (without calling for assistance from staff).During an interview on 3/12/2026 at 3:49 PM with Certified Nursing Assistant (CNA) 2, CNA 2 stated no [facility staff] one informed CNA 2 Resident 23's fall mats were not alongside Resident 23's bed and Resident 23 needed the fall mats while Resident 23 was in bed. CNA 2 stated Resident 23 was more confused in the evening, and Resident 23 had tried to get out of bed unassisted before. CNA 2 stated the fall mats were implemented for Resident 23 after Resident 23's last fall that occurred a couple months ago in January 2026. CNA 2 stated Resident 23 was a high fall risk and could fall very easily.During an interview on 3/13/2026 at 9:23 AM with the Physical Therapist (PT), the PT stated Resident 23 had been receiving physical therapy to improve mobility since Resident 23 fell on 1/7/2026. The PT stated Resident 23's mobility had improved and Resident 23 was able to walk with assistance and sit at the edge of Resident 23's bed independently. The PT stated when Resident 23 was in bed, fall preventions were implemented such as keeping the bed at the lowest position and placing mats on the sides (alongside) of Resident 23's bed so if there was a fall, Resident 23 was protected from injury.During an interview on 3/13/2026 at 9:54 AM with the Director of Nursing (DON), the DON stated residents (in general) at risk for falls were placed on the facility's fall prevention program which included interventions such as keeping the bed at the lowest (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	position and using fall mats while the resident was in bed. The DON stated if the fall mats were not used, the resident was at increased risk of injury if a fall occurred. During a review of the facility's policy and procedure (P&P) titled, Fall Prevention Program, dated 2/2009, the P&P indicated the purpose of the fall prevention program was to improve or maintain the quality of life for community residents by properly assessing their risk for falling, providing adequate interventions to minimize risk, and then evaluating the effectiveness of those interventions. The P&P indicated the nursing function in a fall prevention program includes recognizing that a fall prevention program functions around the clock, informing ancillary staff of interventions to be used and monitoring staff compliance, and providing timely intervention to minimize risk.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure Labetalol Hydrochloride (medication used to treat high blood pressure [BP], HCL, unit of measurement) was held in accordance with holding parameters for one of three sampled residents (Resident 5). On 3/11/2026, Resident 5's BP was 117/58 millimeters of mercury [mm Hg, unit of pressure measurement]), Licensed Vocational Nurse (LVN) 1 did not hold the medication and administered 300 milligrams (mg, unit of measurement) of Labetalol Hydrochloride to Resident 5.This deficient practice had the potential to result in dizziness due to a further drop in BP and a physical decline to Resident 5.Findings:During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 8/23/2017 with diagnoses that included hypertensive heart disease with heart failure (when long-term high blood pressure [hypertension] makes it harder for the heart to pump blood making it more difficult for the heart muscle to relax) and cerebral infarction (stroke).During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 5 had intact cognition and was dependent on staff for showers/bathing self and toileting hygiene.During a review of Resident 5's Medication Administration Record (MAR), dated March 2026, the MAR indicated to hold Labetalol HCL for parameters of Systolic (S, pressure exerted by blood on artery walls when the heart contracts and pumps blood out into the body) BP below 110 or diastolic (D, the pressure in the arteries when the heart relaxes between beats) BP below 60 starting 11/11/2024.During an observation and concurrent interview on 3/11/2026 at 10:10 AM, with Licensed Vocational Nurse (LVN) 1, LVN 1 checked Resident 5's BP by placing the BP cuff on the right wrist. LVN 1 checked Resident 5's BP a second time on Resident 5's left wrist and Resident 5's BP was 117/58 mm Hg.During a medication administration observation on 3/11/2026 from 10:10 AM to 10:30 AM, LVN 1 administered 1 tablet of Labetalol Hydrochloride (HCL) 300 milligrams (mg) with other scheduled medications.During a concurrent review and interview on 3/11/2026 at 10:40 AM with LVN 1. Resident 5's MAR, dated March 2026. LVN 1 stated LVN 1 administered Labetalol outside the holding parameters and this administration could lead to lower DBP which could potentially cause Resident 5 to develop weakness and dizziness. LVN 1 stated LVN 1 would notify Resident 5's physician and would monitor Resident 5's BP because Labetalol HCL was administered in error.During an interview on 3/13/2026 at 1:50 PM, with the Director of Nursing (DON), the DON stated the facility did not have a Policy and Procedure on significant medication errors. The DON stated administering Labetalol outside of the parameters was a medication error and the error could lead to further drop in Resident 5's BP.During a review of the facility's Policy and Procedure (P&P) titled Medication Administration, General Guidelines, dated 1/2023, the P&P indicated medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices, and only by persons legally authorized to do so.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure two pill crushers were cleaned and the medication rooms were maintained free of food items.These failure had the potential to contribute to cross contamination of the residents' medications During a review of the facility's map, the map indicated the facility has two medication rooms located in nurses' stations 1 and 2.During a concurrent observation and interview on 3/12/2026 at 8:35 AM with Licensed Vocational Nurse (LVN) 3, in the nurses' station 1, the pill crusher had a reddish-brown color on the hinges and unidentified orange , white and yellow colored powder residue. LVN 3 stated the pill crushers are required to be cleaned daily at the end of each shift to prevent cross contamination of medications and avoid potential unintended chemical interactions.During a concurrent observation and interview on 3/12/2026 at 12:45 PM with Licensed Vocational Nurse (LVN) 2 in the nurses' station 2, the pill crusher had a whitish powder residue. LVN 2 stated the pill crushers are to be cleaned daily at the end of each shift to maintain infection control standards.During a concurrent observation and interview on 3/12/2026 at 1:34 PM with Registered Nurse (RN) 1 in the nurses' station 1 medication room, a bag of chips and an empty beverage cup were inside one of the medication room drawers. RN 1 stated food items should not be kept in the medication rooms because they can attract bugs into those areas. In the nurses' station 2 medication room, an opened lunch bag was inside the cabinet used for medication storage.During an interview on 3/11/2026 at 2:20 PM, with the Infection Preventionist (IP), IP stated that the facility has an infection control program that includes compliance audits and monitoring of adherence to infection prevention standards, with a focus on safety and sanitation practices.During an interview on 3/12/2026 at 3:25 PM, with the Director of Nursing (DON), DON stated nurses are responsible for cleaning pill crushers to prevent medication cross contamination and food items are prohibited in the medication rooms.During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and control Program, dated 2/9/2026, the P&P indicated the facility's program includes monitoring of infection control practices, environmental cleaning, education and competency assessment.During a review of the facility's P&P titled, Medication Administration, dated 1/2023, the P&P indicated that medications are to be crushed within a plastic bag or pouch to prevent direct contact between the medication and the crushing device.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify food preferences and offer food substitutes for one of three sampled residents (Resident 4).This failure had the potential to adversely affect Resident 4's nutritional intake, dining experience, and overall quality of life.During a review of Resident 4's face sheet, the face sheet indicated Resident 4 had an initial admission on [DATE] with the diagnoses but not limited to: wedge compression fracture (a break or discontinuity in bone tissue) of first lumbar vertebra(one of the bones that make up the spinal column), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic polyneuropathy (a common complication of long-term diabetes characterized by nerve damage affecting multiple peripheral nerves throughout the body),hypertensive (high blood pressure) heart, chronic kidney disease (a long-term condition in which the kidneys are damaged) and legal blindless.During a review of Resident 4's Minimum Data Set (MDS-a resident assessment tool) dated 2/25/2026, the MDS indicated Resident 4 needs partial/moderate assistance on eating. Resident 4 has an active diagnosis that includes cataract (a clouding of the eye's natural lens), glaucoma (a group of eye conditions that damage the optic nerve), macular degeneration (a progressive eye disease that primarily affects central vision)During a review of Resident 4's care plans dated 2/19/2026, the care plans indicated Resident 4 is at risk for nutritional deficit. The interventions in the care plan include offering substitutes for food not eaten and assessing food preferences.During a review of Resident 4's order summary dated 2/24/2026, the order summary indicated Resident 4 was on a consistent carbohydrate diet, regular texture, regular consistency with a dietary supplemental health shake two times a day.During an interview on 3/10/2026 at 9:52 AM, with Resident 4, Resident 4 stated no one asked about his daily preferences nor offer satisfying food substitutes such as finger foods that support a more comfortable eating experience, especially given that Resident 4 is blind.During a concurrent observation and interview conducted on 3/12/2026 at 9:05 AM, with Certified Nursing Assistant (CNA) 3 and Resident 4, inside Resident 4's room, Resident 4's breakfast tray had scrambled eggs, a bread roll and slices of oranges. Resident 4 refused to eat the scrambled egg and CNA 3 did not ask for his preferences or offer substitutes. CNA 3 stated Resident 4 should consume whatever is on the meal served.During an interview on 3/12/2026 at 10:55 AM with the Certified Dietary Manager (CDM), CDM stated residents' meals are based on the registered dietician's nutrition recommendations which include the diet, texture, allergies, and preferences. CDM stated that Resident 4's preferences were only gathered at admission and were not reassessed daily.During an interview on 3/12/2026 at 3:18 PM with the Registered Dietician (RD), RD stated it is important to understand each resident's choices and preferences to provide appropriate meal alternatives. RD stated the dietary aides along with the CDM identify residents' preferences during admission and as needed.During a review of the facility's policy and procedure (P&P) titled, Resident Food Services-Resident Dining Profile and Food preferences, the P&P indicated individual food and dining preferences incorporating religious, cultural, ethnic and portion sizes are obtained from residents on a regular basis. Food substitutions are provided when the resident chooses not to consume meal items served and should be of equal nutritional value to the planned menu. Update preferences on admission, annually, and/or as desired by resident.

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	03/13/2026

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

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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. During a concurrent observation and interview on 3/10/2026 at 9:20 AM with the Kitchen Cook, five half gallon containers of milk with a best used by date of 2/26/2026 were found in the kitchen refrigerator. The Kitchen [NAME] stated expired milk should not be kept in the refrigerator, as it could be mistakenly served to the residents and potentially cause illness.During an interview on 3/11/2026 at 9:15 AM with the Director of Dining Services (DDS), DDS stated expired food items, including milk, must be discarded because retaining them in the refrigerators poses a potential health hazard to the residents.During a review of the facility's policy and procedure (P&P) titled, Production, purchasing, storage, the P&P indicated all food and supplies used in food preparation shall be stored in such a manner as to prevent contamination and maintain safety of the food for human consumption. The refrigerated storage life of food uses manufacturers expiration date and or milk should be plus three days after opening or by expiration date, if sooner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow infection control practices and ensure a safe, sanitary environment for two of two sampled residents (Resident 5 and Resident 15).This deficient practice had the potential to cause healthcare associated infections that can cause pain and discomfort for residents.Findings:1. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 8/23/2017 with diagnoses that included hypertensive heart disease with heart failure (when long-term high blood pressure [hypertension] makes it harder for the heart to pump blood making it more difficult for the heart muscle to relax) and cerebral infarction (stroke).During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool), dated 12/3/2025, the MDS indicated Resident 5 had intact cognition and was dependent on staff for showers/bathing self and toileting hygiene.During an observation on 3/11/2026 at 9:37 AM, Licensed Vocational Nurse (LVN) 1 checked Resident 15's blood pressure (BP) then proceeded with medication administration. LVN 1 placed the BP cuff on top of the medication cart without cleaning or disinfecting the cuff.During an observation on 3/11/2026 at 10:09 AM, LVN 1 was preparing medications for Resident 5.During an observation on 3/11/2026 at 10:10 AM, LVN 1 checked Resident 5's BP on Resident 5's right wrist. LVN 1 did not clean or disinfect the BP cuff before using it on Resident 5.During an interview on 3/11/2026 at 10:40 AM, LVN 1 stated LVN 1 forgot to clean and disinfect the BP cuff after using it on Resident 15 and prior to using it on Resident 5.During a review of the facility's Policy and Procedure (P&P) titled Cleaning of Vital Sign Equipment dated May 2017, the P&P's policy indicated to clean and disinfect BP equipment which is used on multiple residents in order to prevent the spread of infections. The P&Ps procedure indicated the BP cuffs will be disinfected between residents.2. During a review of Resident 15's admission Record (AR), the AR indicated Resident 15 was originally admitted to the facility 3/30/2022 and readmitted on [DATE]. The AR indicated Resident 15's diagnoses included dementia (gradual decline in mental abilities), congestive heart failure (long standing progressive condition where the heart muscle cannot pump blood efficiently to meet the body's needs), and arthritis (group of conditions that cause joint inflammation, pain, stiffness, and swelling affecting movement and quality of life).During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool), dated 1/16/2026, the MDS indicated Resident 15's cognition (the ability to think and process information) was intact.During an observation on 3/11/2026 at 1:21 PM, LVN 1 was providing wound care to Resident 15. LVN 1 was not wearing personal protective equipment (PPE -equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) while providing wound care and there was no sign at Resident 15's door indicating PPE was to be worn.During an interview on 3/13/2026 at 10 AM, Infection Preventionist (IP) 1 stated the facility did not put Resident 15 on Enhanced Barrier Precautions (EBP- extra measures, like wearing gowns and gloves, used during high-contact care activities with residents who are at a higher risk [wounds] of having or spreading germs that are hard to treat, like multidrug-resistant organisms [MDROs, bacteria that have become resistant to certain antibiotics [medication used to treat bacterial infections], and these antibiotics can no longer be used to control or kill the bacteria]) because Resident 15 only had a skin tear which was not a major wound.During a telephone interview on 3/13/2026 at 1 PM, Resident 15's wound care physician (Physician 2) stated Resident 15's has a chronic (long standing) wound.During a review of Resident 15's Wound Assessment Report dated 6/25/2025, the report indicated Resident 15 had a reopened right lateral lower leg vascular wound that required daily would care.During a review of Resident 15's Progress Notes (PN) dated 10/24/2025, the PN indicated Resident 15 had a right posterior shin skin tear measuring 1.5 X 1 centimeter (cm, unit of measurement).During a review of Resident 15's PN, dated 3/11/2026, the PN indicated a right posterior shin skin tear measuring 1.5 cm X 1.8 cm and a depth of 0.1 cm. The PM indicated wound care.During a review of the facility's Policy and Procedure (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(P&P) titled Infection Prevention and Control Program dated 6/12/2025, the P&P indicated Enhanced Standard Precautions (ESP): A resident-centered and activity-based approach for preventing MDRO transmission through healthcare provider (HCP) use of gowns and gloves during high-contact resident care activities for those known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition, even if blood and body fluid exposure is not anticipated. The P&P indicated ESP are indicated for high-risk residents, those with infection or colonization with an MDRO when contact precautions do not otherwise apply and/or with wounds and/or indwelling medical devices (urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters) and/or may be considered for residents with functional disability and total dependence. The P&P indicated ESP includes activities that have demonstrated transfer of MDRO to hands and or clothing of HCP (i.e., helping a resident out of bed). ESP allows high-risk SNF residents to participate in activities outside of the room under specified conditions.