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 _____	C 10/20/2023

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 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a Facility Reported Incident. Facility Reported Incident number: CA00864412 Representing the Department: Health Facilities Evaluator Nurse: 42307 The inspection was limited to the specific Facility Reported Incident investigated and does not represent the findings of a full inspection of the facility. One deficiency was identified for Facility Reported Incident number: CA00864412.	F 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Claremont Manor Care Center (CMCC) does not admit that the deficiencies listed on this form exist, nor does CMCC admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. CMCC reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all treatments and services were provided to one of three sampled residents (Resident 1) by failing to follow Resident 1's physician's order to obtain a neurology consult (a medical doctor who specializes, diagnoses, treats and manages	F 684	**F 684 CFR(s): 483.25** **QUALITY OF CARE** **How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** On 11/3/23, Administration coordinated for Resident 1 to have a neurology consult appointment with her existing physician on 2/22/24. Administration is going to work with the facility Medical Director to obtain an appointment sooner if possible. **How the facility will identify other residents having the potential to be**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert Barton Robert Barton — TITLE: Executive Director — (X6) DATE: 11/10/2023

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.

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F 684	Continued From page 1 disorders of the brain and nervous system [brain, spinal cord and nerves]). This deficient practice resulted in Resident 1 not being seen and evaluated by an neurologist and had the potential to cause a negative impact on Resident 1's well-being. Findings: During a review of Resident 1's Face Sheet indicated, Resident 1 was originally admitted on 2/21/20 and readmitted on 7/19/23 with multiple diagnoses including myelodysplastic syndrome (a group of disorders caused by blood cells that are poorly formed or don't work properly) and asthma (a chronic [long-term] condition that affects the airways in the lungs). During a review of Resident 1's History and Physical Examination (H&P) dated 3/10/23, indicated, Resident 1 could make needs known but could not make medical decisions. During a review of Resident 1's Minimum Data Set (MDS, an assessment and screening tool) dated 8/17/23, indicated, Resident 1 ' s cognitive (ability to think and process information) status was intact. During a review of Resident 1's psychiatrist (a medical doctor who can diagnose and treat mental, emotional and behavioral conditions or illnesses) Doctor ' s Progress Notes (DPN) dated 8/23/23, indicated, Resident 1 was awake and alert times two (knows who they are and where they are, but not what time it is or what is happening to them) and not oriented to reality or situation. The DPN indicated, Resident 1 needed	F 684	**affected by the same deficient practice and what corrective actions will be taken:** On 11/3/23 Administration completed an audit of all orders within the past 90 days to identify other residents with neurology consult orders in order to ensure that consults were completed – No other residents identified. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur:** On 11/2/23, the Medical Records Director (MRD) under the coordination of the Administrator implemented a systemic change by creating two specific consult logs (one for each nursing station) for all consult orders received. The Director of Nursing (DON) with the Director of Staff Development (DSD) and/or designee will complete an inservice with licensed nurses to document consult orders received by any means (verbal, telephone, fax, email) on the respective new consult logs in order to ensure all consults are captured and followed up timely including new consult orders received in person when a resident returns from a physician appointment. The consult log will be reviewed on weekdays by the DON, MRD and/or designee for new consult orders and to confirm previous consult orders were completed timely. Any consult orders identified that need further follow up will be reported to the DON and/or designee and discussed with the	

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F 684	Continued From page 2 redirection and reorientation often due to forgetfulness. Resident 1 had paranoia (a rare mental health condition in which you believe and feel that others are unfair, lying, or actively trying to harm you when there's no proof) and persecutory delusions (persistent, troubling, false beliefs that one is about to be harmed or mistreated by others). The DPN indicated, one of the psychiatrist's interventions and plan was to get advice and recommend to follow-up with neurology to rule out dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) due to increased forgetfulness. During a review of Resident 1's Physician Orders dated 8/23/23, indicated, an order to advice/recommend to follow-up with neurology to rule out dementia due to increased forgetfulness. During a review of Resident 1's Physician Orders dated 8/24/23, indicated, an order for a neurology consult to rule out dementia due to increased forgetfulness. During a review of Resident 1's Interdisciplinary Notes (IDT) dated 8/24/23, indicated, Resident 1's primary physician was notified and gave new order to refer Resident 1 for a neurology consult and will be seen for follow-up in one to two months. During an observation and concurrent interview on 10/20/23 at 6:06 a.m., Resident 1 was observed sitting up in her wheelchair with her eyes closed and easily arousable. Resident 1 was oriented to name and birthdate but could not remember details of event.	F 684	interdisciplinary team (IDT) to ensure compliance. **How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system:** The Director of Nursing (DON) and/or designee will review the consultant order log weekly x4 and monthly x3 or until substantial compliance is achieved. Identified issues will be addressed as soon as possible with the IDT with re-education and/or further systemic changes as needed and will be discussed during the monthly quality assurance performance improvement (QAPI) meeting to assist with continued compliance. **Date(s) when corrective action will be completed:** 11/05/2023	

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F 684	Continued From page 3 During a concurrent interview and record review on 10/20/23 at 2:45 p.m. with the Administrator (ADM) and the Interim Director of Nursing (IDON), Resident 1's psychiatrist's DPN dated 8/23/24 indicated, one of the psychiatrist's interventions and plan was to get advice and recommend to follow-up with neurology to rule out dementia due to increased forgetfulness. The IDON stated, there was no documentation that indicated Resident 1 was seen and evaluated by a neurologist. The ADM stated, it was the licensed (staff) who arranges for appointments or consulations and Social Services arranges the transportation. The ADM stated, it was important to follow through with the physician ' s orders and recommendations, "to make sure everything is okay," and because physicians have the knowledge and the expertise and the order, "is the plan of care." During an interview on 10/20/23 at 2:50 p.m. the IDON stated, no documentation could be found and the order for a neurology consult had not been followed through. The IDON stated, it was important to follow through with physician orders for continuity of care. The IDON stated, she had just spoken with Social Services who stated, Resident 1's Emergency Contact 1 (EC 1) who arranges for the appointment and takes the resident. During an interview on 10/20/23 at 3:21 p.m. EC 1 stated, she was not aware of a neurology consult for Resident 1. EC 1 stated, the facility arranges the appointment since there was a big shift how Resident 1 was acting mentally and physically. During a review of the facility's policy and	F 684		

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F 684	Continued From page 4 procedure titled, "Physician Orders, Noting of," revised 2/2009, indicated, "Physician orders will be noted after all portions of the orders have been transcribed appropriately."	F 684		