STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 000	INITIAL COMMENTS	F 000		

The following reflects the findings of the California Department of Public Health during the annual recertification survey.

Total Census - 51

Sample Size - 15

Closed Records - 3

Highest Scope and Severity - E

F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578	

§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other

11/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rich Rodas	Administrator	11/10/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 1	F 578		

entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 9 and Resident 47) and/or their legal representative (RP) were informed and/or provided written information about Advance Directives (AD, legal document, which specifies the health-related actions in accordance with the resident's wishes, that is actuated when the resident is no longer able to make decisions for himself/herself due to illness or incapacity).

These failures violated Resident 9 and Resident 47's right to formulate an AD and had the potential to receive inappropriate or medically unnecessary care and/or treatment or services regarding life-sustaining treatment.

Findings:

a. During a review of Resident 9's "Admission Record (AR)," the "AR" indicated, Resident 9 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 578	Continued From page 2	F 578		

admitted to the facility on 6/2/23 with multiple diagnoses including hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (stroke, result of disruptive blood flow to the brain) affecting left dominant side, unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and apraxia (a disorder of the brain and nervous system in which a person is unable to perform tasks or movements when asked) following cerebral infarction.

During a review of Resident 9's "Minimum Data Set (MDS, a federally mandated resident assessment tool)," dated 8/27/24, the "MDS" indicated, Resident 9's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was severely impaired. The "MDS" indicated, Resident 9 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) to requiring supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) on staff for activities of daily living.

During a review of Resident 9's "History and Physical (H&P)," dated 9/16/24, the "H&P" indicated, Resident 9 did not have the capacity to make decisions.

b. During a review of Resident 47's "AR," the "AR" indicated, Resident 47 was originally admitted to the facility on 8/15/24 and last readmitted on 9/13/24 with multiple diagnoses including chronic obstructive pulmonary disease with acute exacerbation (a sudden and sustained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 578	Continued From page 3	F 578		

worsening of [COPD, a group of lung diseases that block airflow and make it difficult to breathe] symptoms that lasts for several days or weeks), sepsis (a life-threatening complication of an infection), unspecified organism and unspecified atrial fibrillation (an irregular, often very rapid heart rate that commonly causes poor blood flow).

During a review of Resident 47's "H&P," dated 9/17/24, the "H&P" indicated, Resident 47 was oriented to person, place, and time.

During a review of Resident 47's "MDS," dated 9/20/24, the "MDS" indicated, Resident 47's BIMS Summary Score for cognitive status was moderately impaired. The "MDS" indicated, Resident 47 required substantial/maximal assistance (helper does more than half the effort) to setup or clean-up assistance (helper sets up or cleans up; resident completes activity) on staff for activities of daily living.

During a concurrent interview and record review on 10/16/24 at 9:48 a.m. with the Social Services Coordinator (SSC), Resident 9's and Resident 47's medical records were reviewed. The SSC stated, the SSD did not have a copy on file of Resident 9 and Resident 47's AD or the "Acknowledgment Form (AF)." The SSD stated, the "AF" is a form provided to the residents (in general) or the residents' RP to formulate an AD and in the event the resident did not have the capacity to make decisions about the resident's health care, the facility could honor the resident's wishes. The SSC stated, the "AF" must be provided to the resident or the resident's RP within seventy-two (72) hours of admission. The SSC stated it was the SSC who "take care of the"

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	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 578	Continued From page 4 AD. During a review of the facility's P&P titled, "Resident Rights," date revised 3/2022, the P&P indicated, residents had "the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive." During a review of the facility's P&P titled, "Residents' Rights Regarding Treatment and Advance Directives," date revised 9/22/23, the P&P indicated, it was the policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. During a review of the facility's undated P&P titled, "Social Services Coordinator," the P&P indicated, one of the essential duties and responsibilities of the SSC was to review the AD and/or Preferred. Intensity of Care (PIC) with new residents and their families and follow-up with completion of AD and/or PIC.	F 578		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths,	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 636	Continued From page 5	F 636		

goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 636	Continued From page 6 apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a federally mandated resident assessment tool) for one of two sampled residents (Resident 43) was completed accurately in accordance with the facility's policy and procedure (P&P). This failure had the potential for Resident 43 to receive inappropriate care and services based on Resident 43's preferences, goals of care, functional and health status, strengths, and needs. Findings: During a review of Resident 43's "Admission Record" (AR)," the "AR" indicated, Resident 43 was originally admitted to the facility on 8/15/24 and last readmitted on 9/2/24 with multiple diagnoses including dysphagia (swallowing difficulties), oropharyngeal (middle part of the throat behind the mouth) phase, encounter for attention to gastrostomy (a surgical procedure used to insert a tube, often referred to as a "G-tube" through the abdomen and into the stomach) and essential (primary) hypertension (high blood pressure).	F 636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 636	Continued From page 7 During a concurrent interview and record review on 10/16/24 at 3:22 p.m. with the Acting Director of Nursing (ADON), Resident 43's "MDS," dated 8/22/24 and Resident 43's physician orders were reviewed. The MDS indicated, Resident 43's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was moderately impaired. Section N-Medications of the MDS, indicated, Resident 43 was taking anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin) with indication noted. The ADON stated, it was the ADON who was responsible for completing the MDS. The ADON stated, the ADON made a "boo boo" and Resident 43 did not have any orders for anticoagulant medication. The ADON stated, it was important for the MDS to be accurate because the MDS affected the resident's (in general) care. During a review of the facility's P&P titled, "MDS 3.0 Completion," Assessment and Care Planning Policy," date revised 9/26/22, the P&P indicated, residents were assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. The MDS indicated, "According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI (Resident Assessment Instrument) specified by the State."	F 636		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 640	Continued From page 8	F 640		

a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 640	Continued From page 9 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete and transmit the quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment in a timely manner for two of two sampled residents (Residents 28 and Resident 30) as indicated in the Centers for Medicare & Medicaid Services (CMS - a federal agency that manages health care programs in the United States) Resident Assessment Instrument (RAI, a tool used by nursing homes to assess the needs, strengths, and preferences of residents) manual. a. For Resident 28, the MDS was not transmitted within 14 days after discharge from the facility. b. For Resident 30, the MDS was not transmitted within 14 days after admission and discharge. These deficient practices resulted to a late completion and transmission of MDS assessment to CMS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. This had the potential to affect the facility's quality monitoring data. Findings: a. During a review of Resident 28's Face Sheet (FS), the FS indicated Resident 28 was admitted to the facility on 5/17/2024.	F 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 640	Continued From page 10	F 640		

During a review of Resident 28's Client Diagnosis Report (CDR) dated 5/20/2024, the CDR indicated Resident 28 had diagnoses that included atrial fibrillation (irregular heartbeat) and generalized weakness.

During a review of Resident 28's admission MDS dated 5/23/2024, the MDS indicated Resident 28's cognition (ability to understand) was intact and needed moderate assistance (helper does less than half the effort) with bed mobility, lower body dressing and toilet use.

During an interview and concurrent record review of Resident 28's discharge MDS, dated 6/6/2024, with the Acting Director of Nursing (ADON) on 10/18/2024 at 9:44 am, the ADON stated Resident 28's discharge MDS was not completed or signed. The ADON stated, "I forgot about it and I missed sending it to CMS."

b. During a review of Resident 30's FS, the FS indicated Resident 30 was admitted to the facility on 6/6/2024 with diagnoses that included hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar).

During a review of Resident 30's admission MDS dated 6/12/2024, the MDS indicated Resident 30's cognition was intact and required maximal assistance (helper does more than half he effort) with bed mobility (moved to and from lying position, moves side to side), lower body dressing and showers. The admission MDS indicated an assessment completion date of 6/17/2024.

During an interview and concurrent record review of Resident 30's initial assessment MDS dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 640	Continued From page 11	F 640		

6/12/2024 and discharge MDS dated 7/12/2024, with the Acting Director of Nursing/MDS Coordinator (ADON), on 10/18/2024 at 9:34 am, the ADON stated Resident 30's initial and discharge MDS assessment were not transmitted or submitted to CMS. The ADON stated MDS must be submitted to CMS to ensure initial and discharge assessments from all departments were completed.

During an interview and concurrent record review with the Acting Director of Nursing/MDS coordinator (ADON), on 10/18/2024 at 9:44 am, the ADON stated Resident 30's admission and discharge MDS were not submitted 14 days after admission and after discharge to CMS. The ADON stated admission and discharge MDS's must be submitted timely (within 14 days) to CMS for payment and compliance and to indicate assessments were done. The ADON stated the facility did not have a policy for MDS but follow the guidelines of the CMS RAI manual.

During an interview with the Acting Director of Nursing (ADON) on 10/18/2024 throughout the day, the ADON was unable to provide a copy of the MDS 3.0 Submission Report (MDSSR, a document that provides feedback to the facility on whether the data it submitted [to CMS] meets the required standards) for June 2024 and July 2024 to indicate Resident 28 and Resident 30's discharge assessments were submitted to CMS.

A review of the MDS RAI Version 3.0 Manual, Chapter 5: Submission and Correction of the MDS Assessments dated 10/2024 indicated under "Submission Time Frame for MDS Records," admission assessments must be submitted no later than 14 days after the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 640	Continued From page 12 completion date (VO200C2). Further review indicated discharge assessments must be submitted no later than 14 days after MDS completion date (ZO500B)	F 640		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 13	F 655		

resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 42) who was admitted with a suprapubic catheter (a type of medical device tube that helps drain urine from your bladder) had a baseline care plan ("CP" provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan]) developed and implemented within forty eight (48) hours of admission in accordance with the facility's policy and procedure (P&P).

This failure had the potential for Resident 42 not receiving continuity of care and the lack of communication among staff which could lead to decrease in Resident 42's safety and safeguard against adverse events.

Findings:

During a review of Resident 42 "Admission Record (AR)," the "AR" indicated, Resident 42 was originally admitted on 9/12/24 and last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 14	F 655		

readmitted on 10/11/24 with multiple diagnoses including hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction (stroke, result of disruptive blood flow to the brain) affecting right dominant side, acute (severe and sudden in onset) kidney failure and encounter for fitting and adjustment of urinary device (medical device tube used to empty the bladder and collect urine).

During a review of Resident 42's "Minimum Data Set (MDS, a federally mandated resident assessment tool)," dated 10/4/24, the "MDS" indicated, Resident 42's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was moderately impaired. The MDS indicated, Resident 42 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on staff for toileting hygiene. Section H - Bladder and Bowel of the MDS indicated, Resident 42 had an indwelling catheter (including suprapubic catheter and nephrostomy tube).

During a review of Resident 42's "History and Physical Examination (H&P)," dated 10/14/24, the "H&P" indicated, Resident 42 had a suprapubic catheter and Resident 42 the capacity to make own decisions.

During a review of Resident 42's "Order Summary Report (OSR)," dated as of 10/18/24, the "OSR" indicated, an order for "supra pubic catheter 16 FR 10 ml."

During a concurrent observation and interview on 10/17/24 at 8:37 a.m. with Resident 42, Resident 42 was awake in bed and had a suprapubic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 15	F 655		

catheter to gravity draining clear yellow colored urine with the urinary collection bag inside a dark navy colored dignity bag. Resident 42 stated, Resident 42 has had the suprapubic catheter for two (2) months because Resident 42 could not "pee" otherwise.

During a concurrent interview and record review on 10/17/24 at 8:43 a.m. with the Acting Director of Nursing (ADON), Resident 42's medical records were reviewed. Resident 42's medical records including the medical chart did not have any care plans on file. The ADON stated, Resident 42 was admitted on 10/11/24 with a catheter for urinary retention and should have been care planned for it (suprapubic catheter). The ADON stated, a care plan was a plan of care for the resident that included the problem, goal, and interventions. The ADON stated, a baseline care plan should be created within 24 - 48 hours of admission so staff will have a plan on how to take care of Resident 42.

During an interview on 10/17/24 at 9:20 a.m. with the Infection Preventionist (IP), the IP stated, Resident 42 was admitted on 10/11/24 with a suprapubic catheter. The IP stated all residents with catheter(foley, suprapubic) should have a care plan. The IP stated, it was the RN (Registered Nurse) Supervisor who created the baseline care plan upon admission, or the Licensed Nurse could create the CP but the CP had to be reviewed/counter signed by the RN. The IP stated, it was important a base line care plan was created so the staff would know how to take care of Resident 42 "especially with his catheter."

During a review of the facility's P&P titled,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 16 "Baseline Care Plan," date revised 9/26/22, the P&P indicated, the facility would develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care. The P&P indicated; the baseline care plan would be developed within 48 hours of a resident's admission. The P&P indicated; a supervising nurse should verify within 48 hours that a baseline care plan had been developed.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17	F 656		

findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to develop or implement an individualized person-centered care plan for one of one sampled resident(Resident 2) who was at risk for elopement (run away without permission) and had a history of elopement.

This failure had the potential to result in unmet individual needs and the potential to affect the resident's safety and well-being.

Findings:

During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility on 3/15/2024 with diagnoses that included mild cognitive impairment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18	F 656		

(problems with a person's ability to think, learn, remember, use judgement, and make decisions), metabolic encephalopathy (impaired brain function) and abnormal gait and mobility (abnormal walking pattern).

During a review of Resident 2's "Risk of Elopement/Wandering Review (RE/WR)" dated 3/15/2024, and 6/17/2024, the RE/WR indicated the resident was at risk for elopement and had a history of leaving the facility without need of supervision or informing staff.

During a review of Resident 2's Physician's Order (PO) dated 5/9/2024, the PO indicated for Resident 2 to have a wander guard (wearable device that helps keep track of residents who are at risk of wandering) for exit seeking behavior.

During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/18/2024, the MDS indicated Resident 2 was cognitively impaired. The MDS indicated Resident 2 had wandering behavior and if the resident had eloped, this would place the resident at significant risk of getting to a potentially dangerous place (outside the facility). The MDS indicated Resident 2 needed set-up assistance when walking up to 150 feet and supervision (helper provides verbal cues) from lying to sitting position.

During an interview with Family Member 1 (FM 1) on 10/15/2024 at 10:43 am, FM 1 stated Resident 2 tried to "leave" the facility in the past to go back "home." FM 1 stated a wander guard was ordered for Resident 2 to ensure Resident 2 does not elope from the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19 During an observation and concurrent interview with Registered Nurse 1 (RN 1) in Resident 2's room, on 10/17/2024 at 11:01 am, Resident 2 was sitting on a recliner and a four-leg walker was in front of the resident. Upon further observation with RN 1, a wander guard was hanging on Resident 2's walker. RN 1 stated Resident 2 was high risk for elopement, had wandering behavior and had a history of attempting to leave the facility. During an interview and record review of Resident 2's paper and electronic charts (medical record) with RN 1 on 10/17/2024 at 11:08 am, RN 1 stated Resident 2 did not have a care plan for elopement. RN 1 stated there should be a care plan to address the risk for elopement for Resident 2' safety because the resident could escape from the facility, fall, get hurt or even hit by a car outside the facility. During a review of the facility's Policy and Procedure (P&P) titled "Baseline Care Plan," revised on 3/2022, the P&P indicated the facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet the professional standards of quality care.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20	F 657		

includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to revise/update the care plan for two of two sampled residents (Residents 2 and 39) who were assessed as at risk for fall (coming to rest on the ground or lower-level surface).

These deficient practices had the potential for the residents not to receive care specific to their needs and placed the residents at risk for further falls and complications.

Findings:

a. During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21	F 657		

admitted to the facility on 3/15/2024 with diagnoses that included mild cognitive impairment (problems with a person's ability to think, learn, remember, use judgement, and make decisions), metabolic encephalopathy (impaired brain function) and abnormal gait and mobility (abnormal walking pattern).

During a review of Resident 2's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/18/2024, the MDS indicated Resident 2 was cognitively impaired and needed moderate (helper does less than half the effort) with showers, sit to stand, bed to chair transfers and toilet/tub transfers.

During a review of Resident 2's "Fall Risk Assessments (FRA)," dated 7/1/2024, 7/9/2024, and 7/14/2024, the FRA indicated the resident was high risk for falls.

During an interview with Registered Nurse 1 (RN 1) on 10/17/2024 at 11:17 am and concurrent record review of Resident 2's "Report of Incident - Situation, Background, Assessment and Recommendation (SBAR)- Actual or Suspected Fall," under "Acute Suspected or Actual Fall Care Plan (ASAFCP) dated 7/9/2024, 7/10/2024, and 7/14/2024, RN 1 stated Resident 2's ASAFCP care plan was blank and not updated. RN 1 stated it was important to update Resident 2's resident care plan to determine if a specific intervention to prevent further falls was done or needed to be updated.

During a review of the facility's Policy and Procedure (P&P) titled "Care Plan Revisions Upon Status Change," revised 9/26/2022, the P&P indicated the purpose of this procedure is to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22	F 657		

prove consistent process for reviewing and revising the care plan for those residents experiencing a status change. The comprehensive care plan will be reviewed, and revised as necessary ...

During a review of the facility's undated P&P titled "Fall Prevention," the P&P indicated residents who sustain a fall will have a care plan developed or the existing care plan updated at the time of the incident occurs that includes the date fall occurred and measurable objectives and time frames.

b. A review of the admission record indicated Resident 39 was admitted to the facility on 9/4/24, with diagnosis including but not limited to, repeated falls, acute respiratory failure (a life-threatening condition that occurs when the lungs can't get enough oxygen into the blood or remove enough carbon dioxide [a colorless, odorless gas that's naturally present in the air, essentially a waste product that we breathe out when we exhale] from the body) with hypoxia (a condition where the body's tissues and cells don't have enough oxygen to function normally), muscle wasting and atrophy (the decrease in size or wasting away of a body part or tissue).

A review of the Fall Risk Assessment dated 9/5/24, indicated Resident 39 had a total score of 9. According to the assessment tool, Resident 39 was at moderate risk for falls.

A review of the care plan for falls dated 9/5/24, indicated Resident 39 was at high risk for falls/injury related to altered mental status, limited mobility, history of falls, psychotropic (substances that affect the brain to change perception and cognition) medication, and diuretics (a medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23	F 657		

that increases the amount of urine produced by the kidneys, helping the body get rid of excess fluid and salt). The goal indicated Resident 39 would be free of falls through the review date. The care plan interventions included assist resident with mobility, transfers; encourage resident not to get up without assistance, always keep call light within reach, and maintain safe and hazard free environment.

During a review of Resident 39's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 9/11/2024, the MDS indicated Resident 39 was cognitively (the ability to think and process information) intact. The MDS indicated Resident 39 mobility was not attempted due to medical condition or safety concerns and required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with mobility.

A review of the Fall Risk Assessment dated 10/4/24, indicated Resident 39 had a total score of 10. According to the assessment tool, Resident 39 was at high risk for falling.

A review of the Incident Report form indicated Resident 39 had a fall on 10/4/24.

A review of the Situational Background Assessment & Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue the team needs to address) Form, dated 10/4/24, indicated that the recommendation was to remind resident to call for assistance, and keep call light within reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24	F 657		

A review of the interdisciplinary team (IDT) conference record dated 10/6/24, indicated staff found Resident 39 on the floor by her bedside, and Resident 39 told staff that she was trying to put her pants in the laundry. The IDT conference record indicated resident has some periods of confusion and forgetfulness due to dementia. The IDT conference record indicated Resident 39's care plan was reviewed.

During an observation on 10/16/24 at 2:20 PM, Resident 39 was lying in bed asleep.

During an interview on 10/16/24 at 3:13 PM, with Resident 39, Resident 39 stated she was sitting on the edge of the bed and tried reaching for her pants that were sitting on a chair next to her bed. Resident 39 stated she slid off the bed, fell on the ground, and did not sustain any injuries. Resident 39 could not recall what day the fall occurred.

During an interview on 10/16/24 at 4:25 PM, with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that the protocol of the facility was to ensure that safety alarms, safety floor mats, beds are in the lowest position, and call lights are within reach as safety measures for fall risk residents. LVN 5 stated that the care plan should be revised after a fall to address new risk factors and to ensure the current plan is still effective. LVN 5 stated that Resident 39 did not have safety floor mats in place.

During an interview on 10/17/24 at 4:13 PM, with the Director of Nursing (DON), the DON stated that Resident 39 should have had safety floor mats in place. The DON stated that Resident 39's care plan for at risk for falls should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25	F 657		

updated to address the resident's fall from the bed, and to implement more effective strategies and interventions to avoid future falls.

During a review of the facility's P&P titled, "Care Plan Revision Upon Status Change" dated 9/26/2022, the P&P indicated:
1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.
2. Procedure for reviewing and revising the care plan when a resident experiences a status change:
a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable.
b. The MDS coordinator and the IDT will discuss the resident condition and collaborate on intervention options.
c. The team meeting discussion will be documented in the nursing progress notes.
d. The care plan will be updated with the new or modified interventions.
e. Staff involved in the care of the resident will report resident response to new or modified interventions.
f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member.
g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care.
h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure one of 5 sampled residents (Resident 48), who was assessed as a high risk to develop pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) and was admitted without pressure ulcers, received the necessary care and services to prevent a development of a pressure ulcer.

As a result, on 10/1/2024, Resident 48 was identified with a stage 2 pressure injury (an open wound that occurs when the skin breaks, wears away, or forms an ulcer) to the left buttock.

Findings:

A review of the admission record indicated Resident 48 was admitted to the facility on 8/22/24, with diagnosis including but not limited

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 686	Continued From page 27	F 686		

to, end stage renal disease (ESRD, a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis), endocarditis (a life-threatening inflammation of the inner lining of the heart's chambers and valves), and bacteremia (the presence of bacteria in the bloodstream).

A review of the Wound Risk Assessment dated 8/22/24, the assessment indicated Resident 48 was a high risk for skin breakdown.

A review of the care plan dated 8/23/24, indicated Resident 48 was risk for developing pressure sore, bruising, and other types of skin breakdown related to reduced mobility, immobility, incontinence of bowel and bladder, diabetes mellitus (a chronic disease that occurs when the body can't use glucose [blood sugar] properly, coronary artery disease (a condition that occurs when the coronary arteries, which supply blood and oxygen to the heart, become narrowed or blocked), and aging process. The care plan approaches and interventions included assess risk using wound risk assessment on admission, turn and position as needed when in bed or wheelchair, encourage resident to assist with turning and positioning changes as tolerated, explain the risk and benefit of being out of bed, turning, and repositioning, and clean after each episode of incontinence.

A review of the care plan dated 8/23/2024, indicated Resident 48 had alteration in bowel and bladder function and was always incontinent of bowel and bladder function. The care plan interventions included render good perineal care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 686	Continued From page 28	F 686		

and keep clean and dry after each episode of incontinence.

A review of the Admitting Skin Assessment dated 8/23/24, the assessment indicated Resident 48 had redness to the Sacro-coccyx (tailbone) area.

During a review of Resident 48's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 8/29/2024, the MDS indicated Resident 48 was moderately cognitively (the ability to think and process information) impaired. The MDS indicated Resident 48 required substantial/maximal assistance (when a helper does more than half the effort. Helper lifts or holds trunk or limbs but provides more than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and was dependent (helper does all the effort. Resident does none of the effort to complete the activity. Or assistance of 2 or more helpers is required for the resident to complete the activity) with mobility.

A review of the Situational Background Assessment & Recommendation (SBAR, a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue the team needs to address) Form, dated 10/1/24, the SBAR indicated Resident 48 had an open area to the left buttock a stage 2 pressure injury. The SBAR indicated Resident 48 was mostly bed bound. The SBAR indicated that the recommendation was to keep the area clean, treatment as ordered, apply pressure relieving mattress, and reposition every 2 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29	F 686		

A review of the Weekly Pressure Sore Report dated 10/1/24, the report indicated the wound to the left buttock was a size 2.0 x 1.7 centimeters (cm, a unit of measurement in the metric system that is used to measure lengths of small objects), depth of 0.1cm, red in color, stage 2, and 100 percent (a number that represents a portion out of 100) granulation (the process of forming small particles, the development of new tissue in a wound) tissue.

A review of the Weekly Pressure Sore Report dated 10/8/24, the report indicated the wound to the left buttock was a size 1.8 x 1.6cm, depth of 0.1cm, red in color, stage 2, and 100 percent granulation tissue.

A review of the Weekly Pressure Sore Report dated 10/14/24, the report indicated the wound to the left buttock was a size 1.0 x 1.0cm, depth 0.1cm, red in color, stage 2, and treatment was changed to DuoDerm (a flexible waterproof dressing used to cover a wound and reduce infection) with calazime (a prevention treatment used for diaper rash and skin irritation) ointment.

A review of the Weekly Pressure Sore Report dated 10/17/24, the area had closed and treatment for maintenance only was indicated.

During an observation on 10/18/24 at 08:15 AM, Resident 48 was seen in her room sitting in a wheelchair with a cushion watching television.

During an observation on 10/18/2024 at 10:30 AM, Resident 48 was seen in her room sitting in wheelchair with a cushion watching television.

During an interview on 10/18/2024 at 10:33 AM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 686	Continued From page 30	F 686		

Resident 48 stated staff had not encouraged her to reposition in wheelchair or transfer to bed to allow pressure relief. Resident 48 stated she believed that the pressure sore around her tailbone developed from the lack of repositioning and from the wet diapers. Resident 48 stated the overnight staff took longer than usual to clean and change her wet diapers while in bed. Resident 48 stated staff would hardly encourage or offer to reposition her when she was in bed and while in the wheelchair.

During the same interview on 10/18/2024 at 10:33 AM, Resident 48 stated she developed the pressure sore at the facility but could not recall when it occurred. Resident 48 stated that her thought process was affected due to the heart infection she developed but was slowly regaining it back. Resident 48 stated she was still weak from the waist down and still had no bladder control. Resident 48 stated the use of the adult diapers was due to the loss of bladder control. Resident 48 stated she had better control of her bowels.

During an interview on 10/18/2024 at 10:46 AM, with Certified Nursing Assistant (CNA) 7, CNA 7 stated residents should be repositioned every two hours or as needed. CNA 7 stated repositioning every two hours should be encouraged and offered whether in bed or in a wheelchair. CNA 7 stated the importance of repositioning was to avoid pressure injuries or to prevent worsening of pressure injuries. CNA 7 stated leaving a resident in a wet diaper for an extended period of time can lead to skin breakdown and skin damage.

During the same interview on 10/18/2024 at 10:46 AM, with CNA 7, CNA 7 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 31	F 686		

Resident 48 had not been encouraged or offered to be repositioned while in wheelchair for more than 2 hours and had not been offered to transfer to the bed to allow pressure relief for more than 2 hours. CNA 7 stated that this could lead to further skin breakdown or worsening of the wound and should be encouraged to reduce the amount of time spent in the wheelchair.

During a review of the facility's P&P titled, "Pressure Injury Prevention Management & Guidelines," dated 9/26/22, the P&P indicated it was the policy of the facility to prevent avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries, this included:

A. Preventive Skin Care:
1.Avoid positioning the resident on an area of redness whenever possible.
2.Keep the skin clean and dry.
a. Manage incontinence with absorptive products. Check every 2 hours, and provide perineal care as needed after incontinent episodes. Diaper usage in bed is not recommended.
b. Protect skin from exposure to excessive moisture with barrier products.

B. Repositioning:
1. Reposition all resident at risk of, or with existing pressure injuries, unless contraindicated due to medical condition. Utilize small shifts in repositioning, if otherwise contraindicated.
2. Routine repositioning schedule: every two hours, using both side-lying and back positions. Reposition when in bed, and out of bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 686	Continued From page 32 3. Repositioning techniques: a. Avoid positioning the resident on bony/prominences/turning surfaces with existing pressure injuries, including stage 1. b. Minimize seating time/out of bedtime to promote ischial and sacral wound healing. 4. Pressure Relieving Devices a. Support surfaces do not eliminate the need for turning and repositioning.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 35) receiving oxygen therapy was provided respiratory care and resident safety in accordance with the facility's policy and procedure titled "Oxygen Administration," and professional standards of practice. There was no sign posted on the resident's door indicating oxygen in use. This deficient practice placed Resident 35's safety at risk regarding oxygen usage. Findings:	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 695	Continued From page 33	F 695		

During a review of Resident 35's Admission Record (AR), the AR indicated Resident 35 was admitted to the facility on 5/27/2023 with diagnoses that included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe) and repeated falls.

During a review of Resident 35's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/22/2024, the MDS indicated Resident 35 had impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 35 required maximal assistance (helper set-up and cleans up) with toilet hygiene, showers, and lower body dressing.

During a review of Resident 35's Physician Order's (PO), dated 7/3/2024, the PO indicated for licensed staff to administer oxygen at two (2) to four (4) liters per minute (L/min) via nasal cannula (NC- flexible plastic tubing used to deliver oxygen through the nostrils and the tubing is fitted over the patient's ears) every shift for shortness of breath.

During an observation on 10/15/2024 at 9:41 am, Resident 35 was asleep lying in bed with a nasal cannula connected to an oxygen machine. Upon further inspection of Resident 35's room, there was no sign posted on Resident 35's door to indicate oxygen was in use in the room and that smoking was prohibited.

During a review of Resident 35's "Medication Administration Record," from 10/1/2024 to 10/15/2024, the MAR indicated Resident 35

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 695	Continued From page 34 received oxygen 2L/min every shift, every day. During a concurrent observation and interview in Resident 35's room with Licensed Vocational 3 (LVN 3) on 10/15/2024 at 10:18 am, Resident 35 was awake lying in bed with an ongoing oxygen administration through the NC from the oxygen machine. LVN 3 stated there was no sign posted on Resident 35's door indicating oxygen was in use and that smoking was prohibited. LVN 3 stated, oxygen sign was important so that staff/visitors would be aware that oxygen was being used and proper precautions were needed to avoid the danger of possible fire/explosion. During a review of the facility's Policy and Procedure (P&P) titled, "Oxygen Administration," revised 3/2022, the P&P indicated oxygen is administered to residents who need it, consistent with professional standards of practice ... and the resident's goals and preferences. Oxygen warning signs must be placed on the door of the resident's room where oxygen is in use.	F 695		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 35 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to have a full time Director of Nursing (DON) five (5) days a week, 8 hours a day beginning 3/6/24 up to the present (10/17/24). This deficient practice had the potential to significantly impact the quality of care, overall patient experience and nursing workforce operations in the facility. Findings: During the entrance conference on 10/15/24 at 8:20 am, the Administrator (ADM) stated the facility had an interim/acting Director of Nursing (DON) and was actively looking to hire a fulltime DON. During a review of the facility's medical leave letter of the previous Director of Nursing (DON 1) dated 3/18/24, the medical leave letter indicated DON 1 would be on leave starting 3/6/24.	F 725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 725	Continued From page 36	F 725		

During a review of DON 1's resignation letter, the letter indicated DON 1's last date of employment was on 8/23/24.

During an interview on 10/17/24 at 2:53 PM, with the acting (ADON), the ADON stated there had not been an active fulltime DON for approximately 8 months. The ADON stated as the ADON she was responsible for the oversight of the unit and all the nursing care. The ADON stated ADON would also conduct applicant interviews with an average of 10 applicant interviews per month. The ADON stated ADON was also on-call on weekends in case the facility needed a Registered Nurse (RN) to administer intravenous (IV, within a vein) medications or to start a peripheral IV line. The ADON stated that the facility did have other on-call RNs, but due to other jobs or commitments their schedules would vary.

During the same interview on 10/17/24 at 2:53 PM with the ADON, the ADON stated she was also the acting Director of Staff Development (ADSD). The ADON stated as the acting (ADSD) she was responsible for conducting two days of new hire orientation from 7:30 AM to 4:30 PM. The ADON stated new hire orientation included providing in-services to newly hired licensed nurses and certified nursing assistants (CNA's). The ADON stated as the acting ADSD she conducted monthly in-services as scheduled, and as needed. The ADON stated she assisted other departments in completing portions of orientation related to the health and safety of residents, conducting on the spot tours and orientation for new registry licensed nurses and/or CNA's. The ADON stated she was responsible for

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	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 37	F 725		

performance evaluations for all licensed nurses, and the performance evaluations of all CNA's, which would typically be conducted by the DSD. The ADON stated, as the ADSD she had to conduct the performance evaluations for all CNAs. The ADON stated the previous DSD resigned August 2024 and the facility was actively looking to hire a DSD.

During the same interview on 10/17/24 at 2:53 PM, with the ADON, the ADON stated that her official position was the facility's Minimum Data Set Nurse (MDS). The ADON stated she had fallen behind on several tasks, such as performance evaluations. The ADON stated she had a difficult time overseeing the unit and was unable to actively listen and communicate with residents. The ADON stated taking multiple roles and tasks was overwhelming and she did not have enough time in the day to complete all the tasks required for her to do. The ADON stated, having multiple roles would impact the quality of care and would potentially have a negative impact on residents and staff. The ADON stated, she did her MDS work from 4:00 PM to 9:00 PM (after hours) and functioned as ADON and ADSD from 7:00 AM to 3:00 PM.

During an interview on 10/17/24 at 4:02 PM with the ADM, the ADM stated the facility needed a DON and the facility continued to look for a DON to fill the position.

A record review of the facility's Quality Assurance Committee indicated open position for the DON.

A review of the facility's job description for the DON indicated the DON would ensure the clinical operations are in compliance with federal, state,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 38 and local regulations, the nurse practice act of the state and professional standards of nursing care while honoring person-centered and resident-directed care ...mentors and guides the clinical component of continuous quality improvement in support of a systematic approach to quality clinical care ...monitors the quality of delegated assessments and clinical nursing functions through continuous quality assurance improvement.	F 725		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the facility was free of a medication error rate of 5 percent (%) or greater during the medication pass observation for one of four sampled residents (Resident 109). The facility had 26 opportunities of medication administration (the act of giving a treatment) observed and three of the 26 medications administered were not in accordance with the physician's orders, resulting in a medication error rate of 11.54%. The medication errors consisted of: a. Resident 109's Eliquis (blood thinner) and Multiple Vitamin were not administered as ordered by the physician. b. Resident 109's tear duct was not held with gentle pressure for one minute after	F 759		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 39	F 759		

administration of Brimonidine Tartrate Ophthalmic Solution 0.2% (eye drops to lower pressure in the eye)

These deficient practices placed Resident 109 at risk for adverse consequences and complications.

Cross Reference with F760

Findings:

During a review of Resident 109's Admission Record (AR), the AR indicated the resident was admitted to the facility on 10/12/2024 with diagnoses that included long term use of an anticoagulant (blood thinner), repeated falls, and displaced intertrochanteric fracture of the right femur (a broken right hip).

During a review of Resident 109's care plan titled "Anticoagulant (medication that prevents or reduces clotting of the blood)" dated 10/12/2024, the care plan indicated to administer medications as ordered.

During a review of Resident 109's care plan titled "Peripheral Vascular Disease /Deep Vein Thrombosis (PVD, blood circulating disorder/DVT, blood clots that form in a vein in the body)," dated 10/12/2024, the care plan indicated the resident was at risk for poor circulation to lower extremities (hip to the toes) and to administer medication (Eliquis) as ordered.

During a review of Resident 109's Order Summary Report (OSR) for October 2024, the OSR indicated the following medications were ordered on 10/12/2024 for Resident 109:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 40	F 759		

1. Colace capsule 100 mg PO daily for bowel management (help regulate bowel movements)
2. Eliquis 2.5 milligrams (mg) by mouth (PO) daily for DVT
3. Multiple Vitamin 1 tablet by PO daily for supplements.
4. Brimonidine Tartrate ophthalmic Solution 0.2% instill 1 drop (gtts.) in both eyes in the morning.
5. Gabapentin capsule 300 mg PO TID for neuropathy (nerve problem that causes pain).
6. Trazadone 50 mg PO TID for mild to serve pain
7. Ipratropium-Albuterol solution 3mg/ per vial inhale orally TID (to prevent difficulty breathing)

During a medication pass observation with Licensed Vocational Nurse 5 (LVN 5) on 10/16/2024 at 8:16 am, for Resident 109, LVN 5 prepared the following medications for Resident 109:
1. Colace 100 milligrams (mg) by mouth (PO)
2. Eliquis 2.5 milligrams (mg) by mouth (PO) daily.
3. Multiple Vitamin 1 tablet by PO daily.
4. Brimonidine Tartrate ophthalmic Solution 0.2% instill 1 drop in both eyes in the morning.
5. Gabapentin 300 mg PO three times a day (TID)
6. Trazadone 50 mg PO TID
7. Ipratropium-Albuterol solution 3mg/ per vial inhale orally TID

During the same medication pass observation, Resident 109 took all medications inside Resident 109's mouth, then spat all medications but the Colace capsule on to the resident's chest. Resident 109 stated, "I will take my medication, just not the gabapentin or trazadone." LVN 5 was observed picking up the medications from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 759	Continued From page 41	F 759		

Resident 109's chest and stated, "I cannot give them (pills) to you because you spat them out." LVN 5 proceeded to administer Brimonidine Tartrate; one drop into Resident 109's left and right eye. LVN 5 did not apply gentle pressure on the resident's tear duct after every eye drop. LVN 5 administered the Albuterol solution, walked out of Resident 109's room and placed the remaining pills (Eliquis, multi-vitamins, gabapentin, and trazadone) into the medication waste container. LVN 5 continued to prepare medication for another resident.

During an interview with LVN 5 on 10/16/2024 at 2:28 pm, LVN 5 stated Eliquis, multi vitamins, gabapentin, and trazadone was not administered to Resident 109. LVN 5 stated Resident 109's Nurse Practitioner (NP, a registered nurse with advanced training in diagnosing and treating patients) was informed of the resident's refusal of gabapentin and trazadone. LVN 5 stated "I did not tell her (NP) about the other pills (Eliquis and Multiple Vitamins)". LVN 5 stated, LVN 5 should have administered (Eliquis and Multi-vitamins) because Eliquis is an anti-coagulant used to prevent blood clots. LVN 5 stated when administering eye drops, the tear duct should be held for at least one minute to ensure the medication stays in the eyes. LVN 5 stated the physician's orders needed to be followed.

During an interview with Registered Nurse 1 (RN 1) on 10/17/2024 at 2:28 pm, RN 1 stated Eliquis should have been administered to Resident 109 because the resident had a recent fracture (bone break) and Eliquis thins the blood to avoid complications. RN 1 stated when administering eye drops, the tear duct should be held down for one minute.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 759	Continued From page 42 A review of the facility's Policy and Procedure (P&P) titled "Residents Refusing Medications," dated 9/4/2024 indicated to assist and support residents to take the right medication, in the right dose, by the right route, at the right time, for the right reason, and ensure the right documentation, including the resident's refusal to take their medication. Contact the prescribing doctor immediately. Refusal of medication may indicate changes in the individual that require the doctor to re-evaluate the individual's needs. A review of MedlinePlus, a National Institutes of Health/National Library of Medicine, https://medlineplus.gov/druginfo/meds/a601232.html, an official website of the United Stated Government, indicated to instill Brimonidine Ophthalmic Solution eye drops, follow these steps: gently squeeze the dropper so that a single drop falls into the pocket made by the lower eyelid ...place a finger on the tear duct and apply gentle pressure.	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 109) observed during medication pass was free of significant medication errors by failing to ensure Resident 109's medication Eliquis (blood thinner) was administered as ordered by the physician.	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 760	Continued From page 43	F 760		

This failure had the potential to increase the risk of blood clot for Resident 109 that may cause embolism (a block in an artery caused by blood clot) leading to serious medical complications.

Findings:

During a review of Resident 109's Admission Record (AR), the AR indicated the resident was admitted to the facility on 10/12/2024 with diagnoses that included long term use of an anticoagulant (blood thinner), repeated falls, and displaced intertrochanteric fracture of the right femur (a broken right hip).

During a review of Resident 109's care plan titled "Anticoagulant (medication that prevents or reduces clotting of the blood)" dated 10/12/2024, the care plan indicated to administer medications as ordered.

During a review of Resident 109's care plan titled "Peripheral Vascular Disease /Deep Vein Thrombosis (PVD, blood circulating disorder/DVT, blood clots that form in a vein in the body)," dated 10/12/2024, the care plan indicated the resident was at risk for poor circulation to lower extremities (hip to the toes) and to administer medication (Eliquis) as ordered.

During a review of Resident 109's Order Summary Report (OSR) for October 2024, the OSR indicated the following medications were ordered on 10/12/2024 for Resident 109:
1. Colace capsule 100 mg PO daily for bowel management (help regulate bowel movements)
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	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 760	Continued From page 44 3. Multiple Vitamin 1 tablet by PO daily for supplements. 4. Brimonidine Tartrate ophthalmic Solution 0.2% instill 1 drop (gtts.) in both eyes in the morning. 5. Gabapentin capsule 300 mg PO TID for neuropathy (nerve problem that causes pain). 6. Trazadone 50 mg PO TID for mild to serve pain 7. Ipratropium-Albuterol solution 3mg/ per vial inhale orally TID (to prevent difficulty breathing) During a medication pass observation with Licensed Vocational Nurse 5 (LVN 5) on 10/16/2024 at 8:16 am, for Resident 109, LVN 5 prepared the following medications for Resident 109: 1. Colace 100 milligrams (mg) by mouth (PO) 2. Eliquis 2.5 milligrams (mg) by mouth (PO) daily. 3. Multiple Vitamin 1 tablet by PO daily. 4. Brimonidine Tartrate ophthalmic Solution 0.2% instill 1 drop in both eyes in the morning. 5. Gabapentin 300 mg PO three times a day (TID) 6. Trazadone 50 mg PO TID 7. Ipratropium-Albuterol solution 3mg/ per vial inhale orally TID During the same medication pass observation, Resident 109 took all medications inside Resident 109's mouth, then spat all medications but the Colace capsule on to the resident's chest. Resident 109 stated, "I will take my medication, just not the gabapentin or trazadone." LVN 5 was observed picking up the medications from Resident 109's chest and stated, "I cannot give them (pills) to you because you spat them out." During an interview with LVN 5 on 10/16/2024 at	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 45	F 760		

2:28 pm, LVN 5 stated Eliquis, multi vitamins, gabapentin, and trazadone were not administered to Resident 109. LVN 5 stated Resident 109's Nurse Practitioner (NP, a registered nurse with advanced training in diagnosing and treating patients) was informed of the resident's refusal of gabapentin and trazadone. LVN 5 stated "I did not tell her (NP) about the other pills (Eliquis and Multiple Vitamins)". LVN 5 stated, LVN 5 should have administered Eliquis because Eliquis is an anti-coagulant used to prevent blood clots.

During an interview with Registered Nurse 1 (RN 1) on 10/17/2024 at 2:28 pm, RN 1 stated Eliquis should have been administered to Resident 109 because the resident had a recent fracture (bone break) and Eliquis thins the blood to avoid complications.

A review of the facility's Policy and Procedure (P&P) titled "Residents Refusing Medications," dated 9/4/2024 indicated to assist and support residents to take the right medication, in the right dose, by the right route, at the right time, for the right reason, and ensure the right documentation, including the resident's refusal to take their medication. Contact the prescribing doctor immediately. Refusal of medication may indicate changes in the individual that require the doctor to re-evaluate the individual's needs.

A review of MedlinePlus, a National Institutes of Health/National Library of Medicine, https://medlineplus.gov/druginfo/meds/a601232.html, an official website of the United Stated Government, indicated to instill Brimonidine Ophthalmic Solution eye drops, follow these steps: gently squeeze the dropper so that a single drop falls into the pocket made by the lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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F 760	Continued From page 46 eyelid ...place a finger on the tear duct and apply gentle pressure.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow safe food storage and food handling practices for one of one kitchen (Kitchen 1) and one of one snack/nourishment refrigerator (Refrigerator 1) in accordance with professional standards for food service safety and the facility's policies and procedures (P&P) by failing to: 1. Label/date food items in the kitchen and in the snack/nourishment refrigerator on the unit. 2. Maintain acceptable chemical sanitizing	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 47	F 812		

solution (used to sanitize food contact surfaces) concentration in the kitchen.
3. Maintain proper temperatures of the snack/nourishment refrigerator on the unit.
4. Discard expired foods in the snack/nourishment refrigerator on the unit and Resident 8's food that was brought from home.

These deficient practices put the residents in the facility at risk for food borne illness (illness caused by the ingestion of contaminated food or beverage), contamination of food and/or affect the palatability of the food for the residents.

Findings:

During a concurrent observation of the kitchen and interview on 10/15/24 at 8:20 a.m. with the Executive Chef (EC), the shelf above the stove had multiple spices and seasonings that included:

1. An opened "Sysco" (brand) Classic Salt Kosher with an orange-colored sticker indicating "9/28/24 PM" and had no open or use by dates.

2. An opened 11 oz (ounces) "Sysco" Imperial Ground Thyme with an orange-colored sticker indicating "8/17/24" and had no open or use by date.

3. A box of yellow potatoes, a box of yams, a box of red potatoes, a box of yellow squash that were unlabeled and undated, stored on the bottom of a second shelf on a stainless-steel cart. The EC stated, the date indicated on the orange-colored sticker is the receive date and the food items observed did not have an open or use by date.

During a concurrent observation and interview on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 48	F 812		

10/15/24 at 8:28 a.m. with the EC inside the walk-in refrigerator and the adjacent walk-in freezer, a 1/6 (one sixth) square tin had eight (8) peeled boiled eggs covered in plastic wrap that had no label and undated was inside the walk-in refrigerator. An opened box of three (3) packages of pork butt meat was on the floor inside the walk-in freezer. The EC stated, food items should be stored at least four (4) inches above the floor. The EC stated, foods should be labeled with open date and use by date to keep the product (food) quality and for staff to know when the food item was opened because over time, the food item would not be good and could cause food borne illness.

During a concurrent observation and interview on 10/15/24 at 10:28 a.m. with Certified Nursing Assistant (CNA) 1, Resident 8's bedside table had a box of twelve (12) oz Sprouts (store brand) snickerdoodle cookies with seven (7) cookies inside and a half-eaten cookie on top of the box next to a glass of milk. The box had a store sticker label "Sell by Oct 04, 24." Resident 8 stated, Resident 8's daughter brought the cookies. CNA 1 stated residents (in general) were allowed to have food brought from home and should be labeled. CNA 1 stated, Resident 8's cookies were already over (ten) 10 days old from the sell by date and CNA 1 did not think that Resident 8 should be eating the cookies "just in case she might get bacteria in the cookie, mold" that could cause "mostly GI (gastrointestinal, refers to the organs and tract that digest food and liquids) problems, where they can have tummy issues, they can get sick."

During an interview on 10/16/24 at 3:22 p.m. with the Acting Director of Nursing (ADON), the ADON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 49	F 812		

stated, residents were allowed to bring food from home and Resident 8's cookies should not have been kept at the bedside "for that long, for more than a week," because cookies had milk and might get spoiled and cause Resident 8 to get sick.

During an interview on 10/17/24 at 8:27 a.m. with Cook (CK) 2, CK 2 stated, when staff opened a food item, staff would label the food item with open date and use by date so staff would know the shelf life (the length of time for which an item remains usable or fit for consumption) of the food item.

During a concurrent observation and interview on 10/17/24 at 12:17 p.m. with the Relief Cook (RC) and the EC, the red bucket (chemical sanitizing solution) in the cook station area of the kitchen was tested twice with a Hydrion (brand) test strip. The test strip indicated a reading of 50 ppm (parts per million) both times. The RC stated the red bucket solution was used to sanitize such as the food carts and to wipe down the counters. The RC stated, the concentration should be between 200 (ppm) and 300 to ensure "it's (solution) doing its job of sanitizing." The EC stated, the reading on the test strip indicated "50 (ppm)" and was not the correct concentration to kill bacteria. The EC stated, the reading should be at 200 (ppm).

During a concurrent observation and interview on 10/17/24 at 3:21 p.m. with Licensed Vocational Nurse (LVN) 2, the facility's snack/nourishment "unit" refrigerator inside the "Nourishment Room" by the Nursing Station had an internal temperature of thirty-one (31) degrees Fahrenheit. Inside the unit refrigerator were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 50	F 812		

multiple supply of brand name snacks and nourishments and:

1. A pot pie inside a ziploc bag marked with a resident's first name and the corresponding bed number and was undated.

2. An unopened box of Marie Callender's (brand name) Chicken Pot Pie with the manufacturer's label indicating "BEST BY SEP 17, 2024" and marked with the same bed number.

LVN 2 stated, the temperature of the unit refrigerator should be between 36 and 40 (degrees Fahrenheit) "cuz if it it's too cold, it'll freeze, if it's too hot, it'll spoil." LVN 2 stated if residents ate the food, residents would have stomach "GI" problems. LVN 2 stated, staff should put date and time when they received food items brought from home and toss the food after a day or two.

During a review of the facility's P&P titled, "Food and Supply Storage," date revised 1/2024, the P&P indicated, all food, non-food items and supplies used in food preparation should be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P indicated, the "sell by" date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the "use by", "sell by", "best by", or "enjoy by", date should be discarded. The P&P indicated, cover, label and date unused portions and open packages. The P&P indicated, as with all refrigerated storage, temperature must be maintained at 41 degrees F

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 51 or below. As with the frozen storage, store food items 6" above the floor. During a review of the facility's P&P titled, "Use and Storage of Food Brought to Residents from the Outside," date revised 1/2024, the P&P indicated, food brought in by family or other visitors was permitted, provided care was taken to ensure food was handled properly for safe and sanitary storage and consumption. The outside food must be stored in a container with a tight-fitting lid, clearly labeled with the resident's name and room number, the date the food was brought to the resident, and the use-by date. During a review of the facility's undated P&P titled, "Using Chemicals to Sanitize Food Contact Surfaces," the P&P indicated, the concentration of the quat sanitizing solution must be 200-400 ppm. During a review of the facility's "Refrigerator Temperature Log (RTL)," dated 8/2024, posted on the unit refrigerator door, the "RTL" indicated, temperature range should be 36-40 degrees Fahrenheit. The "RTL" indicated, the temperature was 43 on 8/1/24 on the 11-7 shift. During a review of the facility's "RTL," dated 10/2024, the "RTL" indicated, the temperature was 34 on 10/15/24 on the 3-11 shift.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 53 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain its infection prevention and control program for five of five sampled residents (Residents 14, 159, 208, 209 and 214) by failing to: a. Ensure the blood pressure (BP, the force of the blood pushing against the walls of the arteries) monitor was cleaned and disinfected (remove dirt or stains and apply a chemical to a surface in order to destroy germs) after using it with Resident 209 and before using it for Resident 214. b. Ensure Resident 208's urinal was properly labeled with initials, room number, and bed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 880	Continued From page 54	F 880		

number.

c. Ensure a used 8 oz (ounce) McKesson (brand name) Perineal & Skin Cleanser Rinse-Free (a gentle, specially formulated product that cleans the perineum [area between the anus and genitals] and removes skin irritants) was not kept on top of the toilet tank cover in Resident 14 and Resident 159's restroom.

d. Ensure food items and personal belongings from staff were not kept in the clean "Linen Closet" open shelving cabinet inside the laundry room.

These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for the residents.

Findings:

a. During a review of Resident 209's Admission Record (AR), the AR indicated Resident 209 was admitted to the facility on 10/8/24, with diagnoses including acute respiratory failure (a condition when the lungs cannot get enough oxygen into the blood), heart failure (when the heart muscle doesn't pump enough blood) and muscle wasting and atrophy (the decrease in size or wasting away of a body part or tissue).

During a review of Resident 209's History and Physical (H&P) dated 10/9/2024, the H&P indicated Resident 209 had the capacity to make a decision.

During a review of Resident 214's AR, the AR indicated the resident was admitted to the facility on 10/9/24, with diagnoses including fracture of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

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PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 880	Continued From page 55	F 880		

the right femur (break in the thigh bone), repeated falls and heart failure.
During a review of Resident 214's H&P dated 10/17/24, the H&P indicated Resident 214 had the capacity to make a decision.

During an observation on 10/16/24 at 8:35 AM, Licensed Vocational Nurse 4(LVN 4) removed a wrist BP monitor from the medication cart to check Resident 209's BP, then, LVN 4 placed the used wrist BP monitor back in the medication cart without cleaning and disinfecting.

During an observation on 10/16/24 at 8:47 AM, LVN 4 took the same wrist BP monitor that was not disinfected from the medication cart and used it to check Resident 214's BP.

During an interview on 10/16/24 at 9:16 AM, with LVN 4, LVN 4 stated she did not disinfect the wrist BP monitor after using it on Resident 209 and did not disinfect it before using it on Resident 214. LVN 4 stated she needed to disinfect the BP monitor after and before each use to prevent cross contamination and the possibility of spreading infection to the residents.

During an interview on 10/17/24 at 3:34 PM, with the Acting Director of Nursing (ADON), the ADON stated staff should disinfect the wrist BP monitor and other re-usable equipment before and after each use to prevent infection spreading to other residents.

During an interview on 10/18/24 at 4:30 PM, with the Infection Preventionist (IP), the IP stated all medical equipment in the medication cart should be cleaned and disinfected before and after each use, especially when used between residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 56	F 880		

The IP stated, not disinfecting BP monitor in between residents can lead to the spread of infectious microorganisms and becomes an infection control problem.
During a review of the facility's P&P titled, "Cleaning and Disinfection of Resident-Care Equipment," dated 9/26/2022, the P&P indicated:
a. Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC recommendations in order to break the chain of infection.
b. Multiple-resident use equipment shall be cleaned and disinfected after each use.

b. During a review of Resident 208's AR, the AR indicated Resident 208 was admitted to the facility on 10/2/24, with diagnosis including heart failure, chronic kidney disease (condition characterized by a gradual loss of kidney function over time) and benign prostatic hyperplasia (a condition that occurs when the prostate gland [a gland in the male reproductive system that produces fluid that nourishes and transports sperm] grows larger than normal, which can cause urinary problems).

During a review of Resident 208's Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 10/9/24, the MDS indicated Resident 208 was cognitively (the ability to think and process information) intact. The MDS indicated Resident 208 required substantial/maximal assistance (when a helper does more than half the effort, helper lifts or holds trunk or limbs but provides more than half the effort) with toileting hygiene, bathing and showering self and lower body dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 57	F 880		

During an observation on 10/15/24 at 9:15 AM, Resident 208 in bed A, was observed with a urinal hanging from his bed rail with no initials and marked with bed B. Resident 209 in bed B, was observed with a urinal hanging from his bed rail marked with bed B.

During an interview on 10/15/24 at 9:15 AM, Resident 208 stated he frequently used the urinal and occasionally would call for assistance when he preferred going to the restroom.

During an interview on 10/16/2024 at 3:37 PM, with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 208 and Resident 209 both had urinals marked with bed B. CNA 6 stated this was an infection control issue, as both urinals could have easily gotten mixed and switched causing risk of cross-contamination of infectious diseases. CNA 6 stated both urinals should be properly labeled with resident's initials, room number, and bed to avoid confusion and the possibility of mixing the urinals. CNA 6 stated residents should have their individual urinals and should never be shared.

During an interview on 10/18/24 at 4:00 PM, with the IP, the IP stated urinals should always be correctly labeled with the resident's initials and room number. The IP stated urinals should never be shared or mixed as this can cause cross contamination of bacteria or infectious microorganisms from one person to another.

During a review of the facility's P&P titled, "Infection and Prevention Control Program," dated 9/26/2022, the P&P indicated the facility will maintain an infection prevention and control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 58	F 880		

program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.

c1. During a review of Resident 14 "Admission Record (AR)," the "AR" indicated, Resident 14 was admitted to the facility on 8/15/19 with multiple diagnoses including bilateral primary osteoarthritis of knee (a degenerative joint disease that affects both knees, causing pain, stiffness, swelling, and decreased mobility), anemia (low blood count) and encounter for screening for other viral diseases (type of infection).

During a review of Resident 14's "History and Physical Examination (H&P)," dated 8/5/24, the "H&P" indicated, Resident 14 had the capacity to make own decisions.

During a review of Resident 14's "Minimum Data Set (MDS, a federally mandated resident assessment tool)," dated 10/2/24, the "MDS" indicated, Resident 14's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was intact. The "MDS" indicated, Resident 14 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) to requiring setup or clean assistance (helper sets up or cleans up; resident completes activity) by staff for activities of daily living.

c2.During a review of Resident 159 "AR," the "AR" indicated, Resident 159 was admitted to the facility on 10/9/24 with multiple diagnoses including urinary tract infection (bladder infection),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 59	F 880		

site not specified, unspecified atrial fibrillation (an irregular, often very rapid heart rate that commonly causes poor blood flow) and essential (primary) hypertension (high blood pressure).

During a review of Resident 159's "H&P," dated 10/10/24, the "H&P" indicated, Resident 159 had the capacity to make decisions.

During a review of Resident 159's "MDS," dated 10/13/24, the "MDS" did not indicate Resident 159's BIMS Summary Score for cognitive status and functional status.

During a review of Resident 159's "Resident Transfer Record (RTR)," dated 10/13/24, the "RTR" indicated, Resident 159 was transferred to the General Acute Care Hospital (GACH) on 10/13/24.

During an observation on 10/15/24 at 10:36 a.m., in a double bed occupancy room, the label outside of the room indicated, Resident 159's name posted for A-bed and Resident 14's name posted for B-bed. Bed A was made, orderly and empty. Resident 14 was in B-bed, awake and alert.

During a concurrent observation and interview on 10/15/24 at 10:42 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 14 and Resident 159's shared restroom, a used 8 oz McKesson Perineal & Skin Cleanser Rinse-Free (personal cleanser) marked with a resident's name that was not Resident 14 or Resident 159 was kept on top of the toilet tank cover. CNA 1 stated, Resident 159 was transferred out to the hospital. CNA 1 stated, the personal cleanser should not be kept on top of the toilet tank cover just in case another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

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F 880	Continued From page 60	F 880		

resident (in general) would accidentally use it (personal cleanser), "it's cross contamination." CNA 1 stated, the personal cleanser should have been left in the resident's bedside drawer.

During an interview on 10/17/24 at 9:20 a.m. with the Infection Preventionist (IP), the IP stated, the personal cleanser should be kept at the bedside, not on the sink and should not be on top of the toilet due infection control issue since the personal cleanser could get contaminated. The IP stated the toilet area was considered contaminated.

During an interview on 10/18/24 at 9:18 a.m. with the IP, the IP stated, the resident whose name was on the personal cleanser was admitted prior to Resident 159's admission and that resident was discharged on 10/9/24. The IP stated personal toiletries were either taken by the resident when discharged or the facility must discard them (personal toiletries).

d. During a concurrent observation in the linen room adjacent to the dryer room inside the laundry room and an interview on 10/18/24 at 2:24 p.m. with the Housekeeping Supervisor (HS) and the Housekeeper/Laundry (HK/LY), the following food items were on the ledge of the open shelving wall cabinet: three (3) bananas,, two (2) empty soda cans, a Starbucks (brand name) drink with a straw. A paper plate of pizza covered with a paper plate and a bag of chips were on the top shelf. Multiple personal items including a fanny pack, an opened bag of chips and a can of soda were on the lower shelf. The open shelving wall cabinet had supply of linen including pillows and folded bedspreads stored. The HS stated the food and personal items

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 61 belonged to staff (unnamed). The HS stated, food and personal items should not be kept in the linen closet to prevent bugs, rodents and potential for contamination. The HS stated, the linen closet should be clean. During an interview on 10/18/24 at 2:24 p.m. with the IP, the IP stated, food and staff personal belongings should not be kept in the linen closet because it (food and/or staff personal belongings) could cause cross contamination. The IP stated staff were provided a breakroom and lockers for their personal items. During a review of the facility's policy and procedure (P&P) titled, "Resident Rights," date revised March 2022, the P&P indicated, the resident had the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living. During a review of the facility's P&P titled, "Infection Prevention and Control Program," date revised 4/2024, the P&P indicated, the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines. The P&P indicated, laundry and direct care staff should handle, store, process, and transport linens to prevent spread of infection.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 62	F 919		

The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-

§483.90(g)(1) Each resident's bedside; and
§483.90(g)(2) Toilet and bathing facilities.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal the need for assistance) system was within reach for one of two sampled residents (Resident 25), as indicated on Resident 25's care plans ("CP" [provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan]) and in accordance with the facility's policy and procedure (P&P).

This failure had the potential to result in Resident 25 not having Resident 25's needs met in a timely manner and/or Resident 25 to experience harm if Resident 25 was unable to alert staff during an emergency.

Findings:

During a review of Resident 25's "Admission Record (AR)," the "AR" indicated, Resident 25 was admitted to the facility on 5/5/22 with multiple diagnoses including muscle weakness (generalized), difficulty in walking, not elsewhere classified and history of falling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 63	F 919		

During a review of Resident 25's "CP," titled, "Alteration in Bowel & Bladder Function," date initiated 5/5/22, the "CP" indicated, one of the interventions was to keep the call light within reach.

During a review of Resident 25's "CP," titled, "At high risk for FALLS/INJURY," date initiated 5/2/22, the "CP" indicated, one of the interventions was to keep call light within reach "at all times" and answer the call light promptly.

During a review of Resident 25's "Minimum Data Set (MDS, a federally mandated resident assessment tool)," dated 7/19/24, the "MDS" indicated, Resident 25's BIMS (Brief Interview for Mental Status) Summary Score for cognitive (ability to think and process information) status was intact. The "MDS" indicated, Resident 25 required from substantial/maximal assistance (helper does more than half the effort) to setup or clean-up assistance (helper sets up or cleans up; resident completes activity) on staff for activities of daily living.

During a review of Resident 25's "History and Physical (H&P)," dated 10/4/24, the "H&P" indicated, Resident 25 was wheelchair bound and oriented to time, place, and person.

During a concurrent observation and interview on 10/15/24 at 9:34 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 25's room, Resident 25 was sitting up in a wheelchair positioned on the right side of Resident 25's bed. Resident 25's call light device was looped around Resident 25's left bed grab bar and was out of reach. LVN 1 stated, Resident 25's call light device should be within Resident 25's reach, "always within reach,"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055261	A. BUILDING _____ B. WING _____	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PILGRIM PLACE HEALTH SERVICES CENTER	721 HARRISON AVE CLAREMONT, CA 91711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 919	Continued From page 64 so Resident 25 could call for help at any time and for Resident 25's safety. During an interview on 10/15/24 at 10:28 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, the call light should always be within reach. CNA 1 stated the call light should not be on the opposite side of the bed. CNA stated the call light should be close to the residents so it would be easier for the resident to call staff for help in case the residents needed assistance. CNA 1 stated when the call light was too far to reach it could increase the risk for falls. During a review of the facility's P&P titled, "Call Lights: Accessibility and Timely Response," date revised 4/19/23, the P&P indicated, staff would ensure the call light was within reach of resident and secured, as needed.	F 919		

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 578**

F578 – FORMULATE ADVANCE DIRECTIVE

CORRECTIVE ACTION:
Social Service Coordinator (SSC) contacted responsible parties of Residents 9 and 47 to provide information about Advance Directives on 10/21/24. Information was recorded, documented and included in residents' medical records. Residents' care plan was updated on 10/21/24.

IDENTIFICATION OF OTHERS:
SSC reviewed all resident records on 10/21/24 to verify proper notification and documentation was achieved for Advance Directives and confirmed no other residents were found to have been adversely affected.

MEASURES TO PREVENT RECURRENCE:
The ADON conducted in-service training to Licensed Nurses and Social Services Coordinator (SSC) on 10/18/24 regarding the regulatory requirements for advance directives and consents. Training emphasized the importance of providing residents and their legal representatives with timely written information about advance directives upon admission and throughout their stay, especially if there is a change in their health status.

Medical Records Designee (MRD)/SSC will perform monthly audits of all resident records for the next three months beginning November 2024 to confirm timely, and appropriate Advance Directive notification and documentation occurred. This audit will also review whether advance directive discussions are documented during care plan meetings and follow-up meetings with residents and/or their legal representatives.
After the initial 90-day period, inspections will transition to quarterly inspection as part of the regulatory compliance routine. All inspections will be documented, and any issues identified during inspections will be remedied immediately, with any subsequent follow up documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
MRD/SSD audits of resident records for Advance Directives, will be submitted to the Administrator for review by the QA Committee on a monthly basis, which will be reviewed for three months and then quarterly thereafter to assess the effectiveness of the corrective actions and adjust strategies if needed to ensure solutions are sustained

Signature: Rich Rodas Title: Administrator Completion Date: 10/21/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 636**

F636 – TIMELY ASSESSMENTS

CORRECTIVE ACTION:
MDS reviewed Resident 43's Admission Record and completed resident's Comprehensive Assessment and submitted to CMS on 10/21/24.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency.

MEASURES TO PREVENT RECURRENCE:
In-Service by Administrator to MDS Nurse on 10/21/24 regarding facility policy, "MDS Completion, Assessment and Care Planning Policy" to emphasize importance of submitting accurate assessments, as they have a bearing on the course of residents' care management.

Resident records were reviewed by MDS Nurse on 10/21/24 to ensure completeness and accurate submission of resident assessments. DON/Assignee will perform monthly reviews for the next 90 days of MDS Assessments for completeness and accuracy.
After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.

All inspections will be documented, and any issues identified during inspections will be addressed immediately and subsequent follow-up documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
DON and Administrator will submit the results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 10/21/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 640**

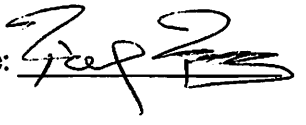
F640 – TIMELY ENCODING/TRANSMITTING RESIDENT ASSESSMENTS

CORRECTIVE ACTION:
MDS/ADON reviewed discharge assessment for Resident 28 and both admission and discharge MDS' for resident 30 for completeness and accuracy. Resident 28's Discharge MDS was transmitted and submitted to CMS on 10/18/24. Resident 30's Admission MDS was confirmed to have been transmitted and submitted to CMS on 06/20/24; Resident 30's Discharge MDS was transmitted and submitted to CMS on 10/18/24. Supporting documents (CMS Submission Reports) are attached for both residents.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency.
Timely transmittal of resident assessments ensure quality monitoring data.

MEASURES TO PREVENT RECURRENCE:
In-Service training conducted by Administrator to MDS Nurse on 10/21/24 regarding "MDS RAI Version 3.0 Manual, Ch. 5, Submission and Correction of the MDS Assessments", the importance of submitting resident assessments within the statutory time frame.
Medical Records will perform monthly inspections for the next 90 days of resident records to ensure timely submission of MDS assessments.
After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during reviews/audits will be addressed immediately, and any subsequent follow up measures documented.

MONITORING PERFORMNACE TO ENSURE SOLUTIONS ARE SUSTAINED:
Medical records will submit results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature:  Title: Administrator Completion Date: 10/21/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 655**

F655 – BASELINE CARE PLAN

CORRECTIVE ACTION:
MDS revised Care Plan for Resident 42 after conducting assessment on 11/10/24, included instructions for care of suprapubic catheter, and resident-centered care.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency.
Effective communication among staff and between the resident or responsible party affects the quality of resident care and ensures the proper continuity of care.

MEASURES TO PREVENT RECURRENCE:
In-Service Training conducted by DSD to Nursing Staff and IDT on requirements for Baseline Care Plan and principles of person-centered care on 10/28/24 with emphasis on Suprapubic Catheter.

Licensed Nurses including DON and MDS Coordinator will create individualized Baseline Care Plan, and members of IDT will review Care Plan on admission to coordinate direction and progress of care, and keep the resident or responsible party informed as to the course of resident's treatment/case.
MDS, DON and IDT will perform monthly inspections for the next 90 days of resident records to ensure coordination among staff and communicating with resident and/or responsible party.
After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during reviews/audits will be addressed immediately, and any subsequent follow up measures documented.

MONITORING PERFORMNACE TO ENSURE SOLUTIONS ARE SUSTAINED:
Medical records and Administrator will submit results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 11/10/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 656**

F656 –COMPREHENSIVE CARE PLAN

CORRECTIVE ACTION:
RN Supervisor conducted assessment of Resident 2 on 10/15/21 regarding risk for elopement. Resident's Care Plan was reviewed and updated on 10/15/24 that addressed resident tendency for elopement and the level of care/assistance necessary for resident's care.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency.
All Care Plans should meet the needs and requirements brought on by resident's health and mental status, in order for the resident to benefit from the services provided by the facility.

MEASURES TO PREVENT RECURRENCE:
In-Service Training conducted by DSD to Nursing Staff and IDT on requirements for Comprehensive Care Plan and principles of person-centered care for residents at risk for wandering on 11/06/24.
Qualified nurses will create individualized Care Plans for all residents, and members of IDT will review Care Plans to coordinate direction and progress of care, and keep the resident or responsible party informed as to the course of resident's treatment/case.

Medical Records Designee (MRD) will perform monthly inspections for the next 90 days of resident records to ensure coordination among staff and communicating with resident and/or responsible party. After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during reviews/audits will be addressed immediately, and any subsequent follow up measures documented.

MONITORING PERFORMNACE TO ENSURE SOLUTIONS ARE SUSTAINED:
MRD will submit results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature:  Title: Administrator Completion Date: 11/06/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 657**

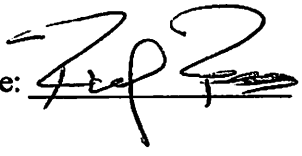
F657 – CARE PLAN TIMING AND REVISION

CORRECTIVE ACTION:
ADON conducted SBAR and Care Plan reviews of Residents 2 and 39 for fall risk and change in condition. Findings were discussed among staff and changes were made in the residents' respective Care Plans to ensure documentation was complete and accurate to address fall risks and fall prevention on 11/10/24.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency. Awareness of residents' changes in condition alert care staff of the need to make adjustments in the residents' courses of treatment/care in order to ensure residents receive the proper care they need/require

MEASURES TO PREVENT RECURRENCE:
In-Service by DSD on 10/28/24 regarding facility policies, "Care Plan Revisions upon Status Change", and "Fall Prevention" to emphasize importance of accurate resident assessments, and provide a process for reviewing and revising the care plan for those residents with a change of condition/status; and addressing residents associated with fall risks.
Resident records were reviewed by ADON on 11/10/24 to ensure completeness and accuracy of resident assessments.
DON/DON Assignee will perform monthly audits for the next 90 days of MDS Assessments for completeness and accuracy. After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during inspections will be addressed immediately; any subsequent follow-up documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
DON will submit the results of audit reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature:  Title: Administrator Completion Date: 11/10/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 686**

F686 – Tx/Svcs to Prevent/Heal Pressure Ulcer

CORRECTIVE ACTION:
ADON conducted assessment of Resident 48 on 10/17/24. Ulcer care protocol initiated on 10/17/24.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency. ADON and Nursing Staff screened other residents for Ulcer signs and symptoms on 10/22/24 and found no other residents to have been affected.

MEASURES TO PREVENT RECURRENCE:
In-Service training by DSD to Nursing Staff on 10/28/24 regarding Skin and Shower Sheets, Ulcer Care, including signs, symptoms, and emphasizing pressure ulcer prevention treatment including repositioning at least q2hrs and as necessary, ensuring call light cord is within reach.

DON/DON Assignee will perform monthly reviews for the next 90 days of Change in Condition reporting and follow up. After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during inspections will be addressed immediately; any subsequent follow-up documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
DON will submit the results of Change of Condition reporting to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: _____ Title: Administrator Completion Date: 10/28/2024

Rich Rodas

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 695**

F695 – RESPIRATORY/TRACHEOSTOMY CARE AND SUCTIONING

CORRECTIVE ACTION:

- Upon being informed of this deficient practice on 10/15/24, LVN 3 posted a "No Smoking" magnetic sign in a position that was easily visible and unobstructed on the outside of the doorway of Resident 35's room.

IDENTIFICATION OF OTHERS:

- All resident rooms with supplemental oxygen use and equipment have the potential to be affected as identified during the inspection and noted within the findings of this deficiency.

MEASURES TO PREVENT RECURRENCE:

- DSD conducted inspections of all resident rooms on 10/24/24 and confirmed all rooms of residents using supplemental oxygen were confirmed to have visible, standardized "No Smoking" signs posted outside each room that are clearly readable from a distance and placed at eye level. A list of these rooms was generated on 10/24/24 to be regularly updated and monitored.
  Assigned Nursing staff received in-service training from DSD on 10/28/24, regarding the requirement of O2 signs being posted when O2 is in use.
  Facility staff will perform monthly inspections for the next 90 days of all rooms with supplemental oxygen to confirm that such rooms have visible, standardized "No Smoking" signs are posted outside. After the initial 90-day inspection period, inspections will transition to a quarterly inspection as part of the preventive maintenance routine.
  All inspections will be documented, and any issues identified during inspections will be addressed immediately, with follow-up actions documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:

- Administrator will submit the inspection reports to the QA Committee on a monthly basis, which will be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 10/28/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 725**

F725 – SUFFICIENT NURSING STAFF

CORRECTIVE ACTION:
HR engaged the services of Recruitment / Placement Companies, to conduct candidate searches to fill the DON position (ongoing)

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency. Absence of DON affects the quality of care delivered by facility, which affects welfare and health of residents.

MEASURES TO PREVENT RECURRENCE:
Facility Administrator coordinates with HR in the process of identification, search and placement of dedicated full-time DON, including: (i) employer/staff referrals, incentives; (ii) advertising; (iii) community outreach (e.g., internships with nursing colleges); (iv) head hunter / placement agencies; (v) promptly responding to qualified applicants.

Administration to address staff retention issues

MONITORING PERFORMANCE:
Facility Administrator will submit the inspection reports to the QA Committee on a monthly basis, which will be review for three months and then quarterly thereafter to monitor the facility's performance and evaluation for further recommendations, to make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 11/10/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 759**

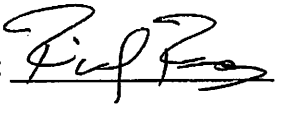
F759 – MEDICATION ERRORS

CORRECTIVE ACTION:
The resident's care plan and medication administration records (MAR) were reviewed to confirm the correct medications are documented, and excepting the medications that were not administered to resident 109 on 10/16/24 at 8:16 am by LVN 5, all required doses have been administered since the deficiency was identified.
The ADON notified the attending physician on 10/18/24 of the missed doses to ensure any potential clinical concerns or adjustments to the medication regimen were promptly addressed. MD recommended monitoring signs or symptoms of blood clotting (swelling of extremities, warm to touch, increase pain, SOB and notify right away of any symptom onset.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency. Medication errors have potential to affect resident's health care status. The resident may be taking unnecessary medications, or if medications are omitted, the quality of care may be compromised.

MEASURES TO PREVENT RECURRENCE:
1:1 In-Service conducted by DSD to LVN 5 on 10/28/24 and ADON and DSD in-serviced all Licensed Nurses including LVN 5 on 11/01/24 regarding: (1) proper administration of medications (2) Handling medication refusals (3) Managing Medication Errors; (4) Administering eye drops; (5) Following MD orders.
MRD will perform monthly reviews for the next 90 days of resident MARS to review the accuracy and timeliness of medication administration for all residents, with a particular focus on high-risk medications. Any discrepancies or missed doses identified in the audit will be immediately investigated and corrected if possible. Follow-up actions will include review of the medication administration process, retraining of staff if necessary, and communication with the attending physician if there is concern regarding medication efficacy or changes to the medication regimen. After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
Pharmacy Consultant will conduct quarterly medication pass audits to inspect accuracy of nurses medication error rate.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
Pharmacy Consultant will submit results of med pass audit to Quarterly QA Committee meetings and DON and Administrator will submit the results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature:  Title: Administrator Completion Date: 11/01/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 760**

F760 – FREE OF SIGNIFICANT MEDICATION ERRORS

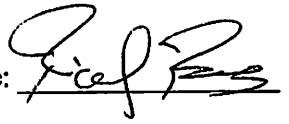
CORRECTIVE ACTION:
The resident's care plan and medication administration records (MAR) were reviewed to confirm the correct medications are documented, and excepting the medications that were not administered to resident 109 on 10/16/24 at 8:16 am by LVN 5, all required doses have been administered since the deficiency was identified.
The ADON notified the attending physician on 10/18/24 of the missed doses to ensure any potential clinical concerns or adjustments to the medication regimen were promptly addressed. MD recommended monitoring signs or symptoms of blood clotting (swelling of extremities, warm to touch, increase pain, SOB and notify right away of any symptom onset.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency

MEASURES TO PREVENT RECURRENCE:
1:1 In-Service conducted by DSD to LVN 5 on 10/28/24 and ADON and DSD in-serviced all Licensed Nurses including LVN 5 on 10/31/24 regarding: (1) proper administration of medications (right medicine, right dose, right delivery route, right frequency, lack of contraindications); and (2) Administering medications; what to do if resident refuses; medication errors; following manufacture's guidelines when administering eye drops; following MD orders.

MRD will perform monthly reviews for the next 90 days of resident MARS to review the accuracy and timeliness of medication administration for all residents, with a particular focus on high-risk medications. Any discrepancies or missed doses identified in the audit will be immediately investigated and corrected if possible. Follow-up actions will include review of the medication administration process, retraining of staff if necessary, and communication with the attending physician if there is concern regarding medication efficacy or changes to the medication regimen. After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
Pharmacy Consultant will conduct quarterly medication pass audits to inspect accuracy of nurses medication error rate.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
Pharmacy Consultant will submit results of med pass audit to Quarterly QA Committee meetings and DON and Administrator will submit the results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature:  Title: Administrator Completion Date: 10/28/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 812**

F812 – FOOD PROCUREMENT

CORRECTIVE ACTION:
The dietary staff members responsible for correct labeling and dating of product immediately labeled and dated the items that were out of compliance. Chef Manager immediately disposed of the food items in the kitchen refrigerator that were opened and unlabeled, including food items from outside that were brought into the facility by the residents' friends and families on 10/15/24. Temperature setting was adjusted on the snack/nourishment refrigerator to be within 34-41 degrees Fahrenheit. All undated and expired items in the refrigerator were disposed on 10/15/24.

IDENTIFICATION OF OTHERS:
The quality of food that is stored, prepared and served to facility residents has the potential to impact the health and well-being of residents, staff and visitors.

MEASURES TO PREVENT RECURRENCE:
Chef Manager created a daily checklist for assigned kitchen staff to check refrigerator contents for proper labeling and storage.
In-Service training done by Chef Manager to kitchen/dining staff regarding safe food handling practices (including completing the daily checklist and safe temperatures for food storage) and Sanitation Logs, testing, Sanitation Buckets on 10/21/24.
In-Service training done by DSD and IP to Nursing staff on facility P/P, "Use and Storage of Food Brought to Residents from the Outside" to address food brought to facility by family and visitors, provided proper steps were taken to ensure safe handling and storage of the outside food.

IP and RD/Executive Chef will perform monthly inspections for the next 90 days of all the facility's refrigerators (including kitchen and resident rooms' refrigerators) to ensure food is properly stored and labeled and acceptable temperature ranges are consistently maintained.
After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during inspections will be addressed immediately; any subsequent follow-up documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
DON and Administrator will submit the results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 10/23/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 880**

F880 – INFECTION PREVENTION

CORRECTIVE ACTION:
The Infection Prevention Nurse (IP) conducted assessments of the affected residents and took the following actions:

1. Cleaned and disinfected blood pressure monitor (Residents 209 and 214) on 10/16/24
2. Inspected urinal used by resident to confirm it was properly labeled with initials, room number, and bed number (Resident 208) on 10/18/24
3. Removed bottle of Perineal & Skin Cleanser from top of toilet tank cover in resident bathroom (Residents 14 and 159) on 10/15/24
4. Removed food items and personal items belonging to staff from the linen closet in the laundry room on 10/18/24

IDENTIFICATION OF OTHERS;
Controlling and preventing bacterial infections through sanitary practices and hygienic controls prevents the spread of infection that could adversely affect the health of all facility residents, staff and visitors.

MEASURES TO PREVENT RECURRENCE;
Infection Preventionist (IP) Nurse and DSD conducted in-service training on 10/28/24to nursing and housekeeping staff of facility P/Ps; "Cleaning and Disinfection of Resident-Care Equipment", "Infection and Prevention Control Program" the purpose of which is to provide a safe, sanitary and comfortable environment by preventing the spread of communicable diseases and infections.

IP Nurse will conduct regular observation of staff infection control and hygiene practice compliance on a monthly basis for the next 90 days.
After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine.
All inspections will be documented, and any issues identified during inspections will be addressed immediately; any subsequent follow-up documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
DON and Administrator will submit the results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 10/28/2024

PILGRIM PLACE HEALTH SERVICES CENTER
RECERT SURVEY **JGIG11**
SURVEY DATE **10/18/24**
POC: **F 919**

F919 – RESIDENT CALL LIGHTS

CORRECTIVE ACTION:
C.N.A. 1 repositioned resident 25'S call light to be within reach for resident's ease of use on 10/15/24.

IDENTIFICATION OF OTHERS:
The facility acknowledges that all residents have the potential to be affected as identified during the inspection and noted within the findings of this deficiency
The call light system is an important element in providing quality patient care, and staff responses to patient call lights may result in patient's needs not being met.

MEASURES TO PREVENT RECURRENCE:
In-service training by DSD to Nursing Staff on 11/04/24 on facility P/P, "Call Lights: Accessibility and Timely Response" to remind staff that call lights would be within reach of residents and secure, if needed.

The Daily Change of Shift (Daily Huddle) includes a reminder to staff to promptly respond and check resident call lights. Nursing Supervisors and Department Heads to conduct random checks for "call light within reach" during their room rounds as scheduled and report findings to DON or supervisor.

DON will track, trend and address findings regarding call lights on a monthly basis for the next 90 days. After the initial 90 day inspection period, reviews will transition to a quarterly basis as part of the regulatory compliance routine. All inspections will be documented, and any issues identified during inspections will be addressed immediately, and any subsequent follow-up actions documented.

MONITORING PERFORMANCE TO ENSURE SOLUTIONS ARE SUSTAINED:
DON and Administrator will submit the results of inspection reports to QA Committee on a monthly basis to be reviewed for three months and then quarterly thereafter to monitor the facility's performance and make necessary adjustments to the corrective action plan as needed to ensure solutions are sustained.

Signature: Rich Rodas Title: Administrator Completion Date: 11/04/2024