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	09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Place Health Services Center	721 Harrison Ave Claremont, CA 91711

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to ensure that one of three residents (Resident 3) received the correct medications at discharge. The discharge nurse provided Resident 3 with blister packs containing medications belonging to two other residents.This failure resulted in Resident 3 ingesting one of the incorrect medications, experiencing nausea, headache, and requiring hospital evaluation.During a review of Resident 3's admission Record (Face Sheet), the facility admitted Resident 3 on 7/17/2025, with diagnoses including diabetes mellitus (DM: long-term metabolic disorder that is characterized by high blood sugar, insulin resistance, and relative lack of insulin) and hypertension (a long-term medical condition in which the blood pressure in the arteries is persistently elevated).During a review of Resident 3's History and Physical (H&P), dated 7/18/2025 indicated Resident 3 had the mental capacity to make medical decisions. During a telephone interview on 9/12/2025 at 11:12 AM with Resident 3, Resident 3 stated she took one of the medications provided by the facility. Resident 3 stated she took pantoprazole (Protonix-medication used to treat conditions that cause too much stomach acid) before realizing the medications did not belong to her but belonged to other residents. Following ingestion, she developed body aches, vomiting, hives, and elevated blood pressure. She was taken to the hospital via ambulance where she was monitored and treated symptomatically for one day.During an interview on 9/12/2025 at 3:50 PM with the Director of Nursing (DON), the DON stated Resident 3 was given medications that were not hers at discharge. It was an honest human mistake. This error should not have occurred.During a review of Resident 3's Hospital records indicated that Resident 3 accidentally ingested Protonix 40 mg (milligrams) that was not prescribed to her. The resident presented with nausea and headache, was monitored, and discharged the same day with follow-up instructions.During a review of the facility's policy and procedure titled, Review of the facility's policy titled Transfer and Discharge (including AMA) (revised 9/26/22) indicated: The nurse caring for the resident at the time of discharge is responsible for ensuring the Discharge Summary is complete and includes . reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter).

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE