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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 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 admitted to the facility on [DATE] 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. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 47's AR, the AR indicated, Resident 47 was originally admitted to the facility on [DATE] and last readmitted on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease with acute exacerbation (a sudden and sustained 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 [DATE], 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 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.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 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 [DATE] and last readmitted on [DATE] 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). 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 [DATE] 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.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 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 [DATE]. 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 [DATE], 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 [DATE], 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 [DATE] with diagnoses that included hypertension (elevated blood pressure), and diabetes mellitus (elevated blood sugar). During a review of Resident 30's admission MDS dated [DATE], 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. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and concurrent record review of Resident 30's initial assessment MDS dated [DATE] and discharge MDS dated [DATE], 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 completion date (VO200C2). Further review indicated discharge assessments must be submitted no later than 14 days after MDS completion date (ZO500B)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 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 [DATE] and last readmitted on [DATE] 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 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. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 [DATE] 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, 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.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 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 [DATE] 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 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. 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. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 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 admitted to the facility on [DATE] 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 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. 50016 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. A review of the admission record indicated Resident 39 was admitted to the facility on [DATE], 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 [DATE], 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 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 [DATE], 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. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 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 [DATE], with diagnosis including but not limited 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 [DATE], 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 and keep clean and dry after each episode of incontinence. A review of the Admitting Skin assessment dated [DATE], the assessment indicated Resident 48 had redness to the Sacro-coccyx (tailbone) area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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, 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 3. Repositioning techniques: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 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: During a review of Resident 35's Admission Record (AR), the AR indicated Resident 35 was admitted to the facility on [DATE] 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 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.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50016 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. 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 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 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 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 [DATE] 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) 2. Eliquis 2.5 milligrams (mg) by mouth (PO) daily for DVT 3. Multiple Vitamin 1 tablet by PO daily for supplements. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (continued on next page)

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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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 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. 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 [DATE] 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) 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: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 eyelid .place a finger on the tear duct and apply gentle pressure.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 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 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] at 8:28 a.m. with the EC inside the walk-in refrigerator and the adjacent walk-in freezer, a ,d+[DATE] (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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] 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 [DATE]. 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 [DATE] at 3:22 p.m. with the Acting Director of Nursing (ADON), the ADON 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 [DATE] at 8:27 a.m. with [NAME] (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 [DATE] at 12:17 p.m. with the Relief [NAME] (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 [DATE] 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 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 [NAME] 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Food and Supply Storage, date revised ,d+[DATE], 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 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 ,d+[DATE], 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 ,d+[DATE] ppm. During a review of the facility's Refrigerator Temperature Log (RTL), dated ,d+[DATE], posted on the unit refrigerator door, the RTL indicated, temperature range should be ,d+[DATE] degrees Fahrenheit. The RTL indicated, the temperature was 43 on [DATE] on the ,d+[DATE] shift. During a review of the facility's RTL, dated ,d+[DATE], the RTL indicated, the temperature was 34 on [DATE] on the ,d+[DATE] shift.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50016 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 number. c. Ensure a used 8 oz (ounce) [NAME] (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 [DATE], 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 [DATE], with diagnoses including fracture of 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 [DATE], 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. 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 42307 c1. During a review of Resident 14 Admission Record (AR), the AR indicated, Resident 14 was admitted to the facility on [DATE] 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 [DATE] with multiple diagnoses including urinary tract infection (bladder infection), 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 [DATE], the MDS did not indicate Resident 159's BIMS Summary Score for cognitive status and functional status. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [NAME] 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 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 [DATE]. 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/[NAME]), 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 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. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42307 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 [DATE] with multiple diagnoses including muscle weakness (generalized), difficulty in walking, not elsewhere classified and history of falling. 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, so Resident 25 could call for help at any time and for Resident 25's safety. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.