

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/05/2025
NAME OF PROVIDER OR SUPPLIER Pilgrim Place Health Services Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on interview and record review, the facility failed to ensure three of four sampled residents' (Resident 11, Resident 59 and Resident 73) had consistent and accurate records and information regarding Advance Directives (AD - legal document indicating resident preference on end-of-life treatment decisions) filed in the resident's medical records (chart). This failure had the potential to cause confusion among staff and Resident 11, Resident 59 and Resident 73 to receive inappropriate or medically unnecessary care and/or treatment or services regarding life-sustaining treatment. Findings: a. During a review of Resident 11's admission Record (AR), the AR indicated, Resident 11 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition, and abnormalities of gait and mobility (when a person is unable to walk in a typical way). During a review of Resident 11's undated History and Physical (H&P), the H&P indicated, Resident 11 did not have decision making capacity. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 9/25/2025, the MDS indicated, Resident 11's cognitive skills (ability to think and process information) for daily decision making were moderately impaired. b. During a review of Resident 59's AR, the AR indicated, Resident 59 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified atrial fibrillation (an irregular heartbeat) and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 59's H&P, dated 11/13/2025, the H&P indicated Resident 59 did not have the capacity to make own decisions. During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59's cognitive skills for daily decision making were moderately impaired. c. During a review of Resident 73's AR, the AR indicated Resident 73 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including sepsis (a life-threatening blood infection) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's cognitive skills for daily decision making were independent (decisions consistent/reasonable). During a review of Resident 73's H&P, dated 12/1/2025, the H&P indicated, Resident 73 had the capacity to make own decisions. During a concurrent interview and record review on 12/3/2025 at 3:22 PM with the Social Services Coordinator (SSC), Resident 11, Resident 59, and Resident 73's charts were reviewed. When asked, what is an AD? The SSD stated, an AD was when a resident appointed someone to make medical decisions in the event the resident could no longer make medical decisions. Resident 11's chart had an Advance Directive Acknowledgement (ADA), form dated 10/17/2024 and an ADA dated 11/28/2025. The ADA dated 10/17/2024 indicated Resident 11 had not executed an AD. The ADA dated 11/28/2025 indicated Resident 11 had executed an AD. The SSC stated there was no copy of an AD in Resident 11's chart. The SSC stated there was an error in the ADA dated 11/28/2025. Resident 11's chart had a blank Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals (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	regarding specific medical treatments that can or cannot be done at the end of life). The SSC stated, if the POLST was not filled out, or there was no POLST, the resident was a full code (medical personnel would do everything possible to save your life in a medical emergency). Resident 59's ADA dated 9/17/2025 indicated, Resident 59 had not executed an AD and had a Durable Power of Attorney for Health. An ADA dated 11/13/2025 indicated Resident 59 had executed an AD. Resident 59's chart had a copy of a Durable Financial Power of Attorney (DPOA), dated 2/4/2023. The SSC stated, there was no AD in Resident 59's chart and stated Resident 59's financial DPOA did not address Resident 59's medical wishes, nothing, nothing at all. Resident 73's ADA dated 11/25/2025 was blank and indicated a signature by Registered Nurse Supervisor (RN) 1. The SSC provided the revised copy of Resident 73's ADA, dated 12/3/2025, originally dated 11/25/2025. The SSC stated the revised copy was just completed during today's care meeting. The revised copy indicated, Resident 73 had executed an AD, the option I have not executed an AD was encircled. Resident 73's ADA form indicated the resident had a Durable Power of Attorney for Health. There was no copy of Resident 73's AD in the chart. The SSC stated the SSC made a mistake filling out the ADA form. Resident 73's POLST dated 11/25/2025 was incomplete. The SSC provided another copy of Resident 73's POLST, dated 10/23/2025 that was not in Resident 73's chart. The POLST dated 10/23/2025 indicated, an AD dated 12/24/2009 was available and reviewed and no AD. The POLST indicated, the POLST complemented an AD and was not intended to replace that document [AD]. The SSC stated, Resident 73 did not have a DPOA indicating health advance directives, only financial. The SSC lined out the word Health from the Durable Power of Attorney for Health on the ADA documents for Resident 59 and Resident 73 and wrote Financial and encircled SSC's initials. The SSC stated, ensuring the records in the chart were filled out accurately was important in the event of an emergency, and for staff to know how to act properly and knew what to do with the resident and how to care for the resident. During a review of the facility's SSC Job Description (JD), date revised 6/2021, the JD indicated one of the essential duties and responsibilities of the SSC included completing advance directives with accurate and complete documentation when appropriate with referral to local Ombudsman for Durable Power of Attorney for Health Care, etc. During a review of the facility's policy and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directives, date revised 1/2025, the P&P indicated the facility supported and facilitated a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directives. The P&P indicated, upon admission, should the residents have an advance directive, copies would be made and placed on the chart as well as communicated to the staff. During a review of the facility's P&P titled, Completion and Management of POLST Forms, date revised 7/2025, the P&P indicated, it was the policy of the facility to ensure the POLST was properly completed, signed, stored, communicated, honored, and reviewed.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure that physician orders for PRN (on as-needed basis) psychotropic drugs (a substance that affect the mind, emotions, and behavior) for Lorazepam (a commonly used drug to reduce anxiety and agitation) included the required 14-day stop-date for two of five sampled residents (Residents 98 and 101). This failure had the potential to result in unnecessary or prolonged exposure to psychotropic medications, risk of adverse drug reactions, oversedation, increased fall risk, and diminished ability to evaluate the resident's ongoing need for the medication. Findings: During a review of Resident 101's admission Record (AR), the AR indicated the facility admitted Resident 101 on 6/28/2024, and re-admitted the resident on 11/19/2025, with diagnoses including muscle weakness, difficulty in walking, and anxiety (a natural feeling of worry, fear, or unease about future events) disorder. During a review of Resident 101's Minimum Data Set (MDS - a resident assessment tool), dated 11/26/2025, the MDS indicated Resident 101's cognition (the ability to think and process information) was intact. During a review of Resident 98's AR, the AR indicated the facility admitted Resident 98 on 12/1/2025, with diagnoses including history of falls, anxiety disorder, and difficulty in walking. During a review of Resident 98's Brief Interview for Mental Status (BIMS) Evaluation, dated 12/2/2025, the BIMS indicated Resident 98's cognition was intact. During a review of Resident 98's OSR, dated active as of 12/3/2025, the OSR indicated to administer Lorazepam oral tablet 1mg and to give 1 tablet by mouth every 24 hours PRN for anxiety manifested by verbalizing feeling anxious, dated 12/1/2025. The PRN psychotropic physician order for Lorazepam did not include a 14-day stop date. During a review of Resident 101's Order Summary Report (OSR), dated active as of 12/4/2025, the OSR indicated an order to administer Lorazepam tablet 0.5mg (mg, metric unit of measurement) and to give 1 tablet by mouth every 8 hours PRN for anxiety manifested by verbalizing feeling anxious, dated 11/19/2025. The PRN psychotropic physician order for Lorazepam did not include a 14-day stop date. During a concurrent interview and record review on 12/3/2025 at 3:50 PM, Resident 98's OSR was reviewed with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 98's PRN order for Lorazepam did not include the required 14-day stop date. LVN 1 stated that having a stop date was fundamental because it ensured the provider reassessed the resident's ongoing need for psychotropic medications. LVN 1 stated that without a 14-day stop date, the medication could be used longer than intended, which had the potential to lead to oversedation, increased fall risk, and unnecessary exposure to a psychotropic drug. During a concurrent interview and record review on 12/4/2025 at 1:07 PM, Resident 101's OSR was reviewed with Registered Nurse (RN) 1, RN 1 stated Resident 101's PRN Lorazepam physician order did not include the required 14-day stop date. RN 1 explained that the 14-day limit was important to ensure resident safety and to determine whether the medication was still needed after 14 days. RN 1 stated if the physician wanted to continue the medication beyond the 14 days, a reassessment was required by the physician to ensure the resident's continued need of the medication. RN1 stated that no reassessment had been completed for Resident 101 and the PRN Lorazepam order was placed on 11/19/2025 (the 14th day was 12/3/2025). RN 1 stated, the order was still active and surpassed the required 14-day limit without a physician reassessment of Resident 101. During an interview on 12/5/2025 at 12:57 PM, with the Director of Nursing (DON), the DON stated that physician orders for PRN psychotropic drugs required a 14-day stop date because psychotropic medications required reassessment [from the physician] to ensure the medication remained necessary and safe for the residents. The DON stated that the 14-day limit was important to prevent unnecessary or prolonged use of the medication, to monitor potential side effects, and to ensure the physician reviewed the resident's status before continuing the PRN psychotropic medication beyond the 14 days. During a review of the facility's Policy and Procedure (P&P) titled, Use of Psychotropic Medication(s) revised 7/2025, the P&P indicated PRN orders for psychotropic medications, excluding antipsychotics, shall (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. During a review of the facility's Policy and Procedure (P&P) titled, Unnecessary Drugs revised 7/2025, the P&P indicated it is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate treatment and services were provided, for two of two sampled residents (Resident 54 and Resident 87), who were at risk for skin breakdown and pressure injuries (PI, localized damage to the skin and underlying soft tissue, usually occurring over a bony prominence or related to medical devices) to prevent skin breakdown. The facility failed to: A. Ensure Resident 54's low air loss mattress (LALM, air-filled mattress used to relieve pressure) was replaced after it was removed due to an air leak. B. Ensure Resident 87's LALM had the correct therapeutic settings. This failure had the potential to compromise pressure redistribution and increased the risk for skin breakdown and pressure injury development for Resident 54 and 87. Findings: A. During a review of Resident 54's admission Record (AR), the AR indicated the facility admitted Resident 54 on 10/29/2025, with diagnoses that included malignant neoplasm of the prostate (cancer of the prostate), secondary malignant neoplasm of the bone (cancer of the bone). During a review of Resident 54's Minimum Data Set (MDS &ndash; a standardized resident assessment tool) dated 11/3/2025, the MDS indicated Resident 54 had moderate cognitive deficit. Resident 54 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) with rolling left and right, lying to sitting on the side of the bed. During a review of Resident 54's care plan titled risk for skin breakdown and other skin problems initiated on 11/11/2025, the care plan's interventions indicated to use pressure reducing mattress if necessary. During a review of Resident 54's Progress Notes dated 11/27/2027 at 2:07 PM, the notes indicated Resident 54's LALM was removed due to an air leak and Resident 54 was currently using a foam topper on [top of] his mattress that was brought by Resident 54's wife. During a review of Resident 54's Order Summary Report (OSR), active orders as of 12/3/2025, the OSR indicated an order for a low air loss mattress (LALM) to aid with wound maintenance of stage 3 wound (a deep wound involving full thickness skin loss, where the fatty layer becomes visible, forming a crater like hole, but muscle, tendon, or bone are not exposed) [on the] coccyx (a triangular bone at the base of the spine) area, order initiated 11/21/2025. During an observation on 12/2/2025 at 4:10 PM, Resident 54 was lying in bed, there was no LAL pump attached to the bed. During a concurrent observation and interview on 12/3/2025 at 2:15 PM with the Treatment Nurse (TN), the TN stated Resident 54 was not lying on a LALM. The TN stated, Resident 54 was lying on a mattress topper placed on top a regular mattress. The TN stated Resident 54's regular mattress felt very firm. The TN stated Resident 54 told the TN Resident 54's LAL was removed around Thanksgiving because the mattress had a leak. During an interview on 12/3/2025 at 2:28 PM, Registered Nurse Supervisor (RN) 1 stated RN 1 was not aware of any concerns regarding Resident 54's LALM. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview with RN 1 on 12/3/2025 at 2:29 PM, Resident 54's Progress Notes, dated 11/27/2025 to 12/3/2025 were reviewed. RN 1 stated there was no record indicating a follow-up was done with the LALM supplier regarding a LALM replacement for Resident 54. RN 1 stated if Resident 54's LALM was not functioning, the LALM needed to be replaced within 24 hours. During an interview on 12/3/2025 at 2:49 PM with the Director of Nursing (DON), the DON stated interventions to prevent and manage pressure ulcers were turning, encouragement to eat and drink, keeping the resident clean, offloading [the body] to remove pressure. The DON stated offloading included the use of a LALM. The DON stated if the LALM was not functioning, the LALM needed to be replaced immediately. B. During a review of Resident 87's AR, the AR indicated the facility admitted Resident 87 on 6/21/2023, with diagnoses including palliative care (specialized medical care focused on relieving symptoms, pain, and stress from a serious illness, aiming to improve the patient's and family's quality of life), muscle wasting and atrophy (a body part or tissue wastes away, shrinks, or loses mass and strength), and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 87's MDS, dated [DATE], the MDS indicated Resident 87's cognition (the ability to think and process information) was moderately impaired. The MDS indicated Resident 87 was dependent (helper does all of the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and dependent with mobility. During a review of Resident 87's OSR, dated active as of 12/4/2025, the OSR indicated Resident 87 had an active order for a LAL mattress, dated 11/5/2025. During a review of Resident 87's Weights and Vitals Summary, dated 12/8/2025, the summary indicated Resident 87's weight was 95 lbs. on 11/6/2025. During an observation on 12/2/2025 at 10:01 AM, Resident 87's LAL mattress' control panel indicated a setting of 450 pounds (lbs., a unit of mass) and was set at the maximum setting. During a concurrent observation and interview on 12/2/2025 at 2:20 PM, with the TN, Resident 87's LAL mattress settings were observed. The TN stated the LAL mattress was set on the maximum setting of 450 lbs., and this setting was too high for Resident 87. The TN stated the LAL mattress was designed to help prevent and treat PIs by redistributing pressure and promoting skin integrity. The TN stated the LAL mattress was only effective when properly set, and if settings were too high, appropriate pressure redistribution, airflow, and moisture management, would not be provided to Resident 87. The TN stated [the correct LAL setting] was critical to prevent skin breakdown and PIs. During a concurrent interview and record review on 12/2/2025 at 2:30 PM, Resident 87's Weights and Vitals Summary was reviewed with the TN. The TN stated Resident 87's most recent recorded weight was documented on 11/6/2025 and indicated Resident 87 weighed 95lbs. The TN stated Resident 87's LAL should have been set between 80 to 130 lbs. During an interview on 12/5/2025 at 12:57 PM, with the DON, the DON stated it was important for staff to ensure LAL mattress settings were properly adjusted according to the resident's current weight. The DON explained that settings that were too high could reduce pressure redistribution and airflow. The DON stated that LAL settings could increase pressure placing the residents (in general) (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at risk for skin breakdown, PIs, and/or worsening of PIs. During a review of the facility's Policy and Procedure (P&P) titled, Pressure Injury Prevention and Management revision date 8/2024, the P&P indicated the facility is committed to the prevention of 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. During a review of the facility's P&P titled, Low Air Loss Mattress Use revision date 7/2025, the P&P indicated [the facility] will provide Low Air Loss (LAL) mattresses for residents who require specialized pressure redistribution surfaces as part of their individualized care plan. LAL mattresses will be used to prevent or manage pressure injuries and to ensure resident comfort and safety, in accordance with CMS regulations, Title 22, and evidence-based pressure injury prevention guidelines. The P&P's purpose indicated to ensure proper use, maintenance, and monitoring of Low Air Loss mattresses to: a. Prevent pressure injury development b. Promote healing of existing pressure injuries c. Reduce moisture and friction d. Support medically indicated off-loading e. Ensure resident safety and comfort The P&P's daily nursing responsibilities indicated nurses must check the LAL mattress every shift for functionality: mattress inflated properly and settings per provider or manufacturer recommendations. During a review of the undated LAL mattress operation manual, Protekt Aire 6000, the operation manual indicated the mattress system is designed for the prevention of bedsores (PIs) and offer an affordable solution to 24-hour pressure area care. The operation manual indicated that the pump and mattress system is intended to reduce the incidence of pressure ulcers while optimizing patient comfort. It also provides the following: individual home care setting and long-term care and pain management as prescribed by a physician. The operation manual's pressure set up indicated users can then easily adjust the air mattress to a desired firmness according to the patient's weight and comfort.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 7 and Resident 36), were provided an environment free of accident (refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident) hazards by failing to, A. Ensure Resident 7's bed was in a low position required to prevent a fall (refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force). B. Ensure a sit-to-stand lift (a mobility device that helps people who can bear some weight but can't stand up on their own, smoothly moving them from sitting to standing [or vice-versa] to go from a bed to a chair or toilet, preventing falls and caregiver strain) was not stored in Resident 36's restroom's doorway and did not block the entry to the bathroom on 12/2/2025. These deficient practices compromised Resident 7 and 36's safety and had the potential to result in accidents to Resident 7 and 36. Findings: A. During a review of Resident 7's admission Record (AR), the AR indicated, Resident 7 was originally admitted to the facility on [DATE] and readmitted the resident on 6/1/2025 with multiple diagnoses including anxiety disorder (a mental health condition marked by excessive, persistent worry and fear) and unspecified abnormalities of gait and mobility (when a person is unable to walk in a typical way). During a review of Resident 7's Care Plan (CP) titled, titled, The resident is at risk for falls r/t [related to] ., date initiated 3/28/2025, the CP's goal indicated Resident 7 would be free of falls through the review date and one of the interventions was to follow the facility's fall protocol. During a review of Resident 7's CP, titled, The resident has had an actual fall on 5/13/2025., date initiated 5/13/2025, the CP's goal indicated Resident 7 would resume usual activities without further incident through the review date. During a review of Resident 7's History and Physical (H&P), dated 6/3/2025 timed at 10 AM, the H&P indicated Resident 7 was oriented to person and mental status was active and alert. The H&P indicated, to provide a safe environment and redirection as indicated. During a review of Resident 7's Fall Risk Evaluation (FRE), dated 8/20/2025 timed at 4:15 PM, the FRE indicated Resident 7's score was 12 and Resident 7 was at risk (of falling). During a review of Resident 7's FRE, dated 9/18/2025 timed at 11:58 AM, the FRE indicated Resident 7's score was 14 and Resident 7 was at risk (of falling). During a review of Resident 7's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 9/18/2025, the MDS indicated, Resident 7's cognitive skills (ability to think and process information) for daily decision making were severely impaired. The MDS indicated, Resident 7 had falls since admission/entry or reentry. During an observation and interview on 12/2/2025 at 10:40 AM, with the Infection Preventionist Nurse (IPN), Resident 7 was lying in bed on Resident 7's left side with his right leg crossed over his left leg and slightly dangling from the bed. Resident 7's bed was high in position, about three (3) feet off the floor. The IPN stated, Resident 7's bed was too high. The IPN stated, Resident 7 usually got up by himself, controlled the bed, and was independent. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 12/2/2025 at 11:03 AM with the IPN, Resident 7 was found on the floor, on the left side of Resident 7's bed, and on top of the floor mat. The IPN stated, Resident 7 was a fall risk and one of the interventions for fall prevention was to always keep the bed low, I should have lowered it immediately. The IPN stated, a bed in high position was a danger and the staff should monitor Resident 7 more often for Resident 7's bed to always [stay] at the safe height since Resident 7 was able to move the bed. During an interview on 12/4/2025 at 8:42 AM with Registered Nurse Supervisor (RN) 1, RN 1 stated keeping the bed (in general) at the lowest position was important to prevent residents from falling and [obtaining] head injuries. RN 1 stated, Resident 7 was a fall risk. During a review of the facility's policy and procedure (P&P) titled, Resident Safety, revised 9/5/2024, the P&P indicated, ensuring the safety of residents in the facility and an environment free from hazards included providing an environment free from fall hazards. During a review of the facility's P&P titled, Fall Prevention Program, revised 7/2025, the P&P indicated each resident would receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The P&P indicated, implementing universal environmental interventions that decreased the risk of resident falling included, but not limited to, a low bed. B. During a review of Resident 36's AR, the AR indicated the facility admitted Resident 36 on 8/29/2011, and re-admitted the resident on 2/11/2024, with diagnoses including rheumatoid arthritis (a chronic [persistent or long-lasting] progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), repeated falls, and difficulty in walking. During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition (the ability to think and process information) was intact. The MDS indicated Resident 36 required partial/moderate assistance (helper does less 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) with mobility. During an observation on 12/2/2025 at 09:47 AM, a sit-to-stand lift was located inside Resident 36's restroom doorway. The lift was positioned in the bathroom doorway, and the lift blocked the entry to the bathroom. During an interview on 12/2/2025 at 9:50 AM, with Resident 36, Resident 36 stated staff used the sit-to-stand lift to help Resident 36 transfer (moving a resident from one flat surface to another) from the bed or wheelchair to a standing position. Resident 36 stated that although Resident 36 needed assistance to stand, Resident 36 was able to move around freely while using Resident 36's wheelchair. Resident 36 stated the lift was sometimes left in Resident 36's bathroom, blocked the doorway, and blocked access to Resident 36's bathroom. Resident 36 stated blocking of Resident 36's bathroom frustrated Resident 36. Resident 36 stated Resident 36 wished they [the facility] stored it [the lift] in a different area. During a concurrent observation and interview on 12/2/2025 at 2:10 PM, Resident 36's restroom was inspected with Certified Nurse Assistant (CNA) 1, CNA 1 stated the sit-to-stand lift should not be stored in Resident 36's restroom because doing so could become a safety hazard. CNA 1 stated the lift was left in Resident 36's restroom's doorway by the previous shift. CNA 1 stated that Resident 36 was generally able to move around when using Resident 36's wheelchair. CNA 1 stated Resident 36 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pilgrim Place Health Services Center		STREET ADDRESS, CITY, STATE, ZIP CODE 721 Harrison Ave Claremont, CA 91711	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sometimes was hesitant to call for assistance [from staff]. CNA 1 stated staff needed to encourage and remind Resident 36 to call for help when using the toilet (located in the bathroom). CNA 1 stated that equipment and devices should never be placed/stored in a manner that created a barrier for residents. During an interview on 12/4/2025 at 2:47 PM, with the Director of Staff Development (DSD), the DSD stated storing a sit-to-stand lift in a resident's restroom (in general) was a major safety concern because it could lead to a fall or injury due to blocking access to the restroom. The DSD stated medical equipment not intended for bathroom use should never be stored in a resident's restroom. The DSD stated staff would be re-educated through in-services to prevent this from occurring again. During a review of the facility's P&P titled, Resident Safety revised 9/5/2024, the P&P indicated that the purpose of this policy was to ensure the safety of residents in the facility, and [maintain an] environment free from hazards for the purposes of: Achieving residents' highest level of functioning Preventing and/or reducing injuries Enhancing the dignity and self-worth of residents The policy's statement indicates Resident safety is an essential component of high-quality care, and keeping residents safe from harm is critically important.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services for two of three sampled residents (Resident 3 and Resident 48) who had indwelling catheters (a medical device that drains urine from your bladder into a bag outside your body) by failing to assess and monitor Resident 3 and Resident 48's indwelling catheter closely for changes in condition and recognizing such changes. This deficient practice could potentially result in serious complications due to the development of urinary tract infections (UTI - an infection in the bladder/urinary tract) to Resident 3 and Resident 48. Findings: During a review of Resident 3's admission Record (AR), the AR indicated, Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for fitting and adjustment of urinary device and retention of urine, unspecified. During a review of Resident 3's Care Plan (CP), titled, The resident has suprapubic catheter [SPC, tube inserted directly into the bladder through a small incision in the abdomen to drain urine], date initiated 7/7/2025, the CP's goals indicated for Resident 3 would not show s/sx (signs and symptoms) of urinary infection (UTI). The CP's interventions indicated to monitor/record/report to MD [Doctor of Medicine] for s/sx of UTI: cloudiness, foul smelling urine. During a review of Resident 3's Order Summary Report (OSR), active orders as of 12/4/2025, the OSR included, an order, dated 7/23/2025 for suprapubic catheter care QS (every shift) and an order dated 9/29/2025 for Enhanced standard barrier precautions (EBP - an infection control guideline for nursing homes that use gowns and gloves for high-contact care activities [like bathing, dressing, transfers] for residents with chronic wounds or indwelling devices or those colonized/infected with Multi-Drug Resistant Organisms [MDROs]) r/t [related to] recurrent UTI. During a review of Resident 3's History & Physical (H&P), dated 7/25/2025, timed at 2 PM, the H&P indicated Resident 3 was able to answer yes or no questions. The H&P indicated Resident 3 had a past medical history of Methicillin Resistant Staphylococcus Aureus (MRSA - a bacteria that does not respond to antibiotics) and Vancomycin Resistant Enterococcus (VRE - a type of bacteria causing healthcare-associated infections, resistant to the antibiotic Vancomycin), and UTI. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 11/25/2025, the MDS indicated, Resident 3's cognitive skills for daily decision making were intact. The MDS indicated Resident 3 had an indwelling catheter (including suprapubic catheter and nephrostomy tube). During a review of Resident 48's AR, the AR indicated, Resident 48 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long standing lung disease causing difficulty in breathing), unspecified and encounter for fitting and adjustment of urinary device. During a review of Resident 48's MDS, dated [DATE], the MDS indicated Resident 48's cognitive skills for daily decision making was moderately impaired. The MDS indicated Resident 48 had an indwelling catheter. During a review of Resident 48's H&P, dated 9/24/2025, the H&P indicated Resident 48 did not have the capacity to make own decisions. During a review of Resident 48's OSR, active orders as of 12/2/2025, the OSR included an order dated 8/1/2024 indicating to monitor foley catheter (type of indwelling catheter) 16Fr (French - size of a urinary catheter) 10 ml (milliliters - a unit of measurement) for urine output, hematuria (blood in urine), cloudy or foul-smelling urine and s/s of infection and notify MD accordingly every shift. During a concurrent observation and interview on 12/2/2025 at 10:42 AM with the Infection Preventionist Nurse (IPN), Resident 3's SPC was draining to gravity and had cloudy colored urine with thick sediments. The IPN stated, Resident 3's catheter needed to be changed or flushed since the catheter was no longer patent or clean and the sediments could go back and cause a UTI. The IPN stated, staff should be assessing the catheter for leakage, sediment build-up, and clean the catheter during rounds. During a concurrent observation and interview on 12/2/2025 at 11 AM with the IPN, Resident 48's foley catheter was draining to gravity and had (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cloudy colored urine with thick sediments. The IPN stated, Resident 48's catheter needed to be flushed, for sure. During an interview on 12/4/2025 at 8:42 AM with Registered Nurse Supervisor (RN) 1, RN 1 stated staff were responsible for checking the catheters like assessing the urine for blood, any sedimentation, cloudiness, grainy, smell throughout the day and should be reporting to RN 1 for RN 1 to look out for UTI, infections. During an interview on 12/5/2025 at 12:10 PM with Certified Nurse Assistant (CNA) 2, CNA 2 stated a resident's (in general) catheter should be checked every shift. CNA 2 stated, CNA 2 found Resident 3 and Resident 48's catheters cloudy sometimes and Resident 3's catheter would have a smell and CNA 2 would notify the charge nurse or treatment nurse who would check and usually flush it. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, date revised 7/2025, the P&P indicated, the facility ensured that residents with indwelling catheters received appropriate catheter care and maintain their dignity and privacy when indwelling catheters were in use. The P&P indicated, catheter care would be performed every shift and as needed by nursing personnel.		

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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** Based on observation, interview and record review, the facility failed to follow safe and proper food storage practices in accordance with professional standards for food service safety and the facility's policy and procedure (P&P) by failing to:1. label/date and store food items properly in the kitchen.2. ensure cold foods were held at 41 degrees or lower during tray line in the kitchen.3. label/date food items inside the unit refrigerator. These deficient practices had the potential to result in a risk for serious complications from food-borne illness (illness caused by the ingestion of contaminated food or beverage) and/or affect the quality and palatability of food and adversely affect the health of the residents. During a concurrent observation and interview on 12/2/2025 at 8:53 AM with the [NAME] (CK), during the initial brief tour of the kitchen, the following was observed inside the Storage Room: 1. A Cambro storage container of uncooked brown rice with a facility generated label Use By: 4-6-26 at 5:17 PM with a teal-colored lid, that was not fully closed, stored on top of a stainless-steel shelving rack2. Multiple unlabeled bags of cornflakes, not in an original box, stored on the top shelf.3. A used 128 Fl oz. (1 gallon) of [NAME] Vinegar with half contents remaining, w/Manufacture Date, Best If Used By [DATE] stored on the shelf along with multiple variety gallons of vinegar. The CK stated, the container of uncooked brown rice should be closed, anything can go in like bugs and dust into the container and residents could get a stomachache. The CK attempted to close the lid but could not close the lid fully. The CK stated, the unlabeled items should be labeled and it was important to label the food items when the food items came in, in order, for the staff to know when to use the food items by.During a concurrent observation and interview on 12/2/2025 at 9:06 AM with the Chef Manager (CFM) while inside the Walk-In Refrigerator Cooler #1, there were six (6) ten (10) pound (lb. - a unit of weight) bags labeled with Vista Foodservice.Potato - Dice [NAME] 3/4 which were undated. The CM stated, the bags should have been labeled when to use by, which was important. Everything has a use by date, especially produce. Undated food items could cause bacteria to grow and cause food borne illness.During a concurrent observation and interview on 12/4/2025 at 11:48 AM with the Executive Chef (EC), during the tray line service in the kitchen, individualized servings of potato salad were observed on ice. Two out of two sampled individualized servings of the potato salad had a temperature of forty-six (46) and forty-three (43) degrees. The EC stated, the temperature of the potato salad should be forty (40) degrees or lower to keep within safe serving temperature to prevent potential bacteria growth.During a concurrent interview and record review on 12/4/2025 at 12:03 PM with the CK, the facility's Community Kitchen Temperature Log (TL), dated 12/4/2025 was reviewed. The CK stated, the cold entree with a temperature of 38 indicated in the TL was the temperature taken from the bin of potato salad inside the refrigerator before putting the potato salad into individual servings. The CK stated, the CK did not check the temperature after the potato salad was prepared into individual servings, I didn't check.During a review of the facility's TL, dated from 12/1/2025 thru 12/4/2025, the TL indicate no 2nd Temperatures were taken.During a review of the facility's P&P titled, Food and Supply Storage, date revised 1/2024, the P&P indicated, all food, non-food items and supplies used in food preparation should be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P indicated, to cover, label and date unused portions and open packages, to complete all sections on a [NAME] orange label or use the Medvantage/Freshdate labeling system, to store foods in their original packages. Foods that must be opened must be stored in NSF approved containers that have tight-fitting lids.During a review of the facility's P&P titled, Meal Quality and Temperature, date revised 1/2024, the P&P indicated, food and drinks were palatable, attractive, and served at a safe and appetizing temperature to ensure resident satisfaction and to meet nutrition and hydration needs. The P&P indicated, to complete taste and temperature log prior to meal service no more than 30 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	minutes prior to start of service and record temperatures of all hot and cold held Time and Temperature Control Foods (TCS) every 2 hours. The P&P indicated, foods should be held cold for service at a temperature of 41 degrees Fahrenheit or less. During a concurrent observation and interview on 12/5/25 at 10:17 AM with Licensed Vocational Nurse (LVN) 2, while in the Nourishment Room, the unit refrigerator had a signage posted on the door, Effective Today November 11, 2025, all food must be labeled with the patient name and date it was placed in the fridge. The following were observed inside the unit refrigerator: 1. An opened package of a 7 oz bag Gallo [NAME] Italian dry [NAME], closed with a bag clip, marked only with a resident's name and no date 2. A small blue and white printed disposable paper bowl marked only with a resident's name with one (1) avocado, three (3) red tomatoes and four (4) small packets of soy sauce, no date, a note indicating to Please prep nicely Gift from [NAME] 47B taped to the bowl 3. A grocery bag marked with only a room and bed number, no name, no date and had a foil covered paper plate with two (2) small containers of salsa inside. LVN 2 stated, the Certified Nursing Assistant (in general) places resident's food from home in the refrigerator. LVN 2 stated, dating the food was important since the facility discarded the food every Friday. LVN 2 stated, residents could get sick, like stomachaches from expired foods. During an observation on 12/5/2025 at 10:39 AM with CNA 1, the grocery bag marked with a room and bed number had a paper plate covered in foil marked chicken and 2 small containers of green and red salsa. During an interview on 12/5/2025 at 1:40 PM with CNA 3, CNA 3 stated, the resident's food brought from home had to be put in the refrigerator, labeled with the resident's name and room number and the date the food was placed in the refrigerator because residents sometimes change their room, and the food might be given to the new resident of the room. CNA 3 stated, dating the resident's food brought from home was important in order to know how old the food was, and to prevent food poisoning, stomachache, diarrhea or nausea. During a review of the facility's P&P titled, Use and Storage of Food Brought to Residents From The Outside, date revised 01/2025, 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 P&P indicated, the outside food must be stored in an appropriate container, labeled with the resident's name and room number, the date the food was brought to the resident, and the use-by date.		

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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** Based on observation, interview and record review, the facility failed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure:1. Twelve out of twelve facility staff (Licensed Vocational Nurse 4 [LVN 4], Certified Nursing Assistant [CNA] 6, CNA 7, CNA 8, CNA 9, Occupational Therapist 1, Physical Therapist 1, the Director of Staff Development (DSD), Infection Prevention Nurse (IPN), Treatment Nurse (TN), Housekeeper 1, and Activity Staff) wore mask during periods of higher levels of community respiratory virus transmission.2. Three out of Twelve facility staff (CNA 6, OT 1, and PT 1) influenza vaccinations were tracked, and the staff were provided education regarding influenza vaccination. 3. CNA 3 and CNA 4 used Personal Protective Equipment (PPE - Personal Protective Equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) correctly and appropriately by using clean gloves during perineal care for two of two sampled residents (Resident 44 and Resident 96).4. A nebulizer mask and oxygen tubing were stored inside a storage bag when not in use for two of two sampled residents (Resident 88 and Resident 96).5. A blood pressure (BP) cuff was disinfected in between resident use for one of two sampled residents (Resident 100).6. Donning (put on) of PPE while assisting one of one sampled resident (Resident 7) who was on enhanced barrier precautions (EBP - an infection control guideline for nursing homes that use gowns and gloves for high-contact care activities [like bathing, dressing, transfers] for residents with chronic wounds or indwelling devices or those colonized/infected with Multi-Drug Resistant Organisms [MDROs]) back to bed while inside Resident 7's room.7. Wound cleanser and skin cleanser products were labeled and stored properly for two of two sampled residents (Resident 3 and Resident 7).Findings: 1. During a review of Resident 40's admission Record (AR), the AR indicated the facility admitted Resident 40 on 10/16/25, with diagnoses that included a displaced fracture of the right femur (broken leg bone), muscle wasting and atrophy (the decrease in size and wasting of muscle tissue caused by not using the muscle enough). During a review of Resident 20's AR, the AR indicated the facility admitted Resident 20 on 7/24/25, with diagnoses that included type 2 diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine), heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs). During a review of Resident 5 AR, the AR indicated the facility admitted Resident 5 on 6/20/19, with diagnoses that included type 2 diabetes, atherosclerotic heart disease (the progressive narrowing and hardening of coronary arteries due to atheroma [degeneration of the walls of the arteries caused by accumulated fatty deposits and scar tissue, and leading to restriction of the circulation] deposition). During a review of Resident 90's AR, the AR indicated the facility admitted Resident 90 on 11/10/25, with diagnoses that included fracture of the left femur, muscle wasting and atrophy. During a review of Resident 96's AR, the AR indicated the facility admitted Resident 96 on 11/21/25, with diagnoses that included UTI, sepsis (infection of the blood). During an observation on 12/2/25 from 9:00 AM to 11:11 AM, the following facility staff were not wearing a mask during resident care at the resident care areas. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 9:00 AM, Licensed Vocational Nurse (LVN) 4 was not wearing a mask while going in and out of resident rooms for medication administration. At 9:36 AM, Infection Prevention Nurse (IPN) was not wearing a mask while inside Resident 96's room to change the nebulizer mask. At 10:09 AM, Certified Nursing Assistant (CNA) 6 not wearing a mask while wheeling a resident down the hallway. At 10:17 AM, Occupational Therapist (OT) 1 was not wearing a mask while pushing Resident 99's wheelchair down the hallway towards the therapy room. At 10:18 AM, Physical Therapy (PT) 1 was not wearing a mask while providing rehabilitation services to Resident 40 inside the therapy room. At 10:22 AM, the Director of Staff Development was not wearing a mask while standing in the hallway in front of the nurse's station, there were residents sitting on wheelchair near the nurse's station. At 10:26 AM, the Treatment Nurse (TXN) was not wearing a mask while going in and out of resident rooms to provide wound care treatment. At 10:38 AM, CNA 7 was not wearing a mask while assisting Resident 20 to the wheelchair inside Resident 20's room. At 10:41 AM, CNA 8 was not wearing a mask while providing care to Resident 5. At 10:52 AM, Housekeeper 1 (HK) 1 was not wearing a mask while going in and out of resident rooms for cleaning. HK 1 stated HK 1 signed up to get the influenza vaccine this year and still waiting to get the vaccine. HK 1 stated wearing a mask is a preference. At 11:09 AM, Activity staff (unidentified) had a mask on, but not covering the nose while providing activities inside the Activity room, there were 5 residents inside the activity room. At 11:11 AM, CNA 9 was wearing a mask, but it was not covering the nose, the mask was on the chin while pushing Resident 90's wheelchair in the hallway. During an interview on 12/2/25 at 11:20 AM, the IPN stated the resident care areas would include the hallway, the nurse's station and the public areas as long as residents were present in the area. During an interview on 12/2/2025 at 2:07 PM, the DSD and IPN stated the facility would refer to the Center for Disease Control (CDC), California Department of Public Health (CDPH) and local guidelines for infection control practices at the facility. The DSD and IPN were not aware of the latest guidelines regarding wearing a mask while at work at the facility. During an interview on 12/2/25 at 4:10 PM, the Director of Nursing (DON) stated the DON checked the updated local guidelines online and would be implementing the use of mask for all facility staff while inside the facility. During a review of the facility's Policy and Procedure (P&P) titled Infection Prevention and Control (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Program revised 7/2025, the P&P indicated the facility has established and maintains 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. During a review of CDC's guidelines titled Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings dated 5/21/25, the guidelines indicated during periods of higher levels of community respiratory virus transmission*, facilities should consider having everyone mask upon entry to the facility to ensure better adherence to respiratory hygiene and cough etiquette for those who might be infectious. Examples reflecting higher levels of community respiratory virus transmission could include months during the typical respiratory virus season (e.g., October-April). During a review of the local Health Officer Order (HOO) dated 10/16/25, the HOO indicated all healthcare personnel (HCP) working in skilled nursing facilities must wear a respiratory mask while working with patients or working in Patient-Care areas throughout the respiratory virus season. 2. During a concurrent observation and interview on 12/2/25 at 10:09 AM, Certified Nursing Assistant (CNA) 6 not wearing a mask while wheeling a resident down the hallway. CNA 6 stated CNA 6 declined influenza vaccine. During a review of Resident 6 vaccination record with the IPN and the DSD on 12/2/25 at 2:07 PM, there was no information regarding CNA 6 vaccination on the log titled Staff Influenza 2025. During an observation on 12/2/25 at 10:17 AM, Occupational Therapist (OT) 1 was not wearing a mask while pushing Resident 99's wheelchair down the hallway towards the therapy room. During a review of OT 1's vaccination record with the IPN and the DSD on 12/2/25 at 2:07 PM, there was no information regarding OT 1's vaccination on the log titled Staff Influenza 2025. Both the IPN and DSD stated there was no vaccine information on the facility's rehabilitation department. During an observation on 12/2/25 at 10:18 AM, Physical Therapy (PT) 1 was not wearing a mask while providing rehabilitation services to Resident 40 inside the therapy room. During a review of PT 1's vaccination record with the IPN and DSD on 12/2/25 at 2:07 PM, there was no information regarding PT 1's vaccination record on the log titled Staff Influenza 2025. During an interview on 12/5/25 at 12:46 PM, the IPN stated the Staff Influenza 2025 log was incomplete, we need to know staff vaccination status so we would know who were the staff that needed education, who needed to sign the declination form and who still needed the recommended vaccines for healthcare personnel. During a review of the facility's P&P titled Influenza Vaccination revised 7/2025, the P&P did not indicate a system of tracking influenza vaccination among healthcare personnel. The P&P indicated it is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza. The P&P indicated staffs medical file will include documentation that the staff was provided education regarding the benefits and potential side effects of immunization, and received or did not receive the immunization due to medical contraindication or refusal. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of CDC's Infection Prevention and Control Strategies for Seasonal Influenza in Healthcare Settings, dated April 28, 2025, the guidance indicated recommendation to promote and administer seasonal influenza vaccine that included tracking influenza vaccination among healthcare personnel can be an important component of a systematic approach to protecting patients and healthcare personnel. 3. During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted Resident 44 on 7/15/24 and readmitted on [DATE], with diagnoses that included urinary tract infection (UTI &ndash; infection of the kidneys, bladder), type 2 diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 44's Minimum Data Set (MDS &ndash; a standardized resident assessment tool) dated 11/12/25, the MDS indicated Resident 44 had moderate cognitive deficit, Resident 44 was dependent with toileting hygiene. During a review of Resident 96's AR, the AR indicated the facility admitted Resident 96 on 11/21/25, with diagnoses that included UTI, sepsis (infection of the blood). During a review of Resident 96's MDS, the MDS indicated Resident 96 had intact cognition and was dependent with toileting hygiene. During an observation on 12/4/25 at 2:30 PM, Resident 96's call light was on, CNA 4 performed hand hygiene, donned PPE (gown and gloves) for enhanced barrier precautions prior to entering the room. CNA 4 touched the curtain to close it around Resident 96's bed, touched another curtain to cover the doorway and touched another curtain covering the window. CNA 4 touched the closet handle to get a diaper from the closet, a pad and cleaning wipes. CNA 4 removed Resident 96's diaper and using the same gloves started to wipe Resident 96's perineal area from front to back, used another wipes to wipe the groin area. During an observation on 12/5/25 at 1:30 PM, CNA 3 performed hand hygiene, put gloves on prior to entering Resident 44's room. CNA 3 then touched the curtain to close it around Resident 44's bed, took wipes from the container and turned on the faucet to wet the wipes under running water. CNA 3 touched the curtain again to close it completely around the bed. CNA 3, using the same gloves, removed the diaper, then started to wipe Resident 44's perineal area from front to back and using different wipes, wiped the groin area. During a concurrent record review and interview on 12/5/25 at 3:40 PM, reviewed the Policy and Procedure (P&P) on perineal care and the IPN stated yes when asked if the P&P indicated to wash hands, put on gloves then proceed to perineal care. The IPN stated facility staff needed to prepare the materials needed for perineal care, wash hands, put gloves then proceed with perineal care. The IPN stated touching the environment around the resident after putting on gloves and using the same gloves puts the resident at risk for infection because the environment could be contaminated with bacteria. 4. During a review of Resident 88's AR, the AR indicated the facility admitted Resident 88 on 11/18/25, with diagnoses that included acute respiratory failure with hypoxia (develops when the lungs can't get enough oxygen into the blood), heart failure. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 88's MDS dated [DATE]/25, the MDS indicated Resident 88 had intact cognition and required moderate assistance with toilet transfer, chair/bed-to-chair transfer. During a review of Resident 96's AR, the AR indicated the facility admitted Resident 96 on 11/21/25, with diagnoses that included UTI, sepsis (infection of the blood). During a review of Resident 96's MDS, the MDS indicated Resident 96 had intact cognition and was dependent with toileting hygiene. During an observation on 12/2/25 at 9:15 AM, upon entering Resident 88's room, there was a nebulizer mask and an oxygen cannula hanging over the wheelchair. Resident 88 stated it would be better to have a new nebulizer mask, that mask had been sitting on that table. During an interview on 12/2/25 at 9:16 AM, LVN 4 stated the nebulizer mask and the O2 tubing needs to be placed inside a storage bag if not being used to prevent contamination. During an observation on 12/2/25 at 9:35 AM, upon entering Resident 96's room, nebulizer mask was on top of the table, not placed inside the storage bag. During an interview on 12/2/25 at 9:36 AM, the Infection Prevention Nurse (IPN) stated the nebulizer mask needed to be placed inside a storage bag when not in use because that mask would be put on for breathing treatment, the mask could potentially be contaminated. During a review of the facility's P&P titled Oxygen Administration revised March 2022, the P&P indicated to keep delivery devices covered in plastic bag when not in use. 5. During a review of Resident 100's AR, the AR indicated the facility admitted Resident 100 on 11/26/25, with diagnoses that included type 2 diabetes, UTI. During a review of Resident 100's History and Physical H&P) dated 11/28/25, the H&P indicated Resident 100 had decision making capacity. During an observation on 12/4/25 at 8:09 AM, LVN 2 was inside Resident 102's room checking Resident 102's blood pressure. LVN 2 came out of the room and placed the BP cuff on top of the medication cart and went back inside Resident 102's room to administer Resident 102's medications. LVN 2 came out of the room and proceeded to prepare Resident 100's medications. LVN 2 went inside Resident 100's room to check the blood pressure without disinfecting the BP cuff before using it on Resident 100. During an interview on 12/4/25 at 8:25 AM, LVN 2 stated LVN 2 forgot to disinfect the BP cuff, LVN 2 stated he needed to disinfect the BP cuff because it was shared between residents. During a review of the facility's P&P titled Cleaning and Disinfection of Resident &ndash; Care Equipment revised date July 2025, the P&P indicated 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. The P&P indicated each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. Wear gloves when cleaning/disinfecting equipment. Use only EPA-registered disinfectants with kill claims for the common organisms found in (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility. If the equipment is exposed to residents on transmission-based precautions, verify the disinfectants are registered for use with the relevant organism. 6. During a review of Resident 7's admission Record (AR), the AR indicated, Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for fitting and adjustment of urinary device and unspecified abnormalities of gait and mobility (when a person is unable to walk in a typical way). During a review of Resident 7's History and Physical (H&P), dated 6/3/2025 timed at 10:00 AM, the H&P indicated, Resident 7 was oriented to person and mental status was active and alert. The H&P indicated, Resident 7 had Methicillin Resistant Staphylococcus Aureus (MRSA &ndash; a bacteria that does not respond to antibiotics) infection, onset 9/17/2024, infection caused by Extended Spectrum Beta-Lactamase (ESBL - a type of bacteria) producing Escherichia coli (a common type of bacteria), onset 11/3/2024, and recurrent urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of Resident 7's Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool), dated 9/25/2025, the MDS indicated, Resident 7's cognitive skill (ability to think and process information) for daily decision making was severely impaired. The MDS indicated Resident 7 had an indwelling catheter. During an observation on 12/2/2025 at 10:11 AM, Resident 7 was asleep in bed on his left side with his right leg crossed over his left leg and slightly dangling off the bed that was in a high position, about three (3) feet off the floor with dark long colored floor mats on both sides. Resident 7 and roommate's (Resident 3) room had a blue and white colored signage for Enhanced Barrier Precautions (EBP - an infection control guideline for nursing homes that use gowns and gloves for high-contact care activities [like bathing, dressing, transfers] for residents with chronic wounds or indwelling devices or those colonized/infected with Multi-Drug Resistant Organisms [MDROs])) signage posted and a white colored 3-drawer PPE cart outside of the room. During a concurrent observation and interview on 12/2/2025 at 11:03 AM with the IPN, Resident 7 was found on the floor, on the floor mat on the left side of Resident 7's bed. Multiple staff (unnamed) arrived without donning PPE prior to assisting Resident 7 back to bed who refused. The IP stated, the staff should have worn gown and gloves because Resident 7 had a Foley catheter attached to a leg bag and on EBP to protect the staff and Resident 7, for infection control. During a review of the undated Centers for Disease Control and Prevention's (CDC &ndash; the national public health agency who provides accurate data, health guidance, and preventive measures) EBP signage poster, the signage poster indicated, providers and staff must also wear gloves and gown for high-contact resident care activities that included transferring and device care or use such as urinary catheter. During a review of the CDC's website https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html: Frequently Asked Questions (FAQ's) Absent Enhanced Barrier Precautions in Nursing Home, dated 6/28/2024, the FAQ's indicated, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). EBP may be applied (when (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status Infection or colonization with an MDRO. During a review of the facility's policy and procedures (P&P), titled Transmission-Based (Isolation) Precautions, date revised 7/2025, the P&P indicated, EBP were to reduce transmission of MDROs in nursing homes. The P&P indicated, EBP involved gown and glove use during higher contact resident care activities for residents to be known to be colonized or infected with an MDRO as well as those at risk of MDRO acquisition (residents with wounds or indwelling medical devices). The P&P indicated, references included the CDC's Frequently Asked Questions (FAQ's) Absent Enhanced Barrier Precautions in Nursing Home. June 2024. 7. During a review of Resident 7's admission Record (AR), the AR indicated, Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for fitting and adjustment of urinary device and unspecified abnormalities of gait and mobility (when a person is unable to walk in a typical way). During a review of Resident 7's History and Physical (H&P), dated 6/3/2025 timed at 10 AM, the H&P indicated, Resident 7 was oriented to person and mental status was active and alert. The H&P indicated, Resident 7 had Methicillin Resistant Staphylococcus Aureus (MRSA &ndash; a bacteria that does not respond to antibiotics) infection, onset 9/17/2024, infection caused by Extended Spectrum Beta-Lactamase (ESBL - a type of bacteria) producing Escherichia coli (a common type of bacteria), onset 11/3/2024, and recurrent urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of Resident 7's Minimum Data Set (MDS &ndash; a federally mandated resident assessment tool), dated 9/25/2025, the MDS indicated, Resident 7's cognitive skill (ability to think and process information) for daily decision making was severely impaired. During a review of Resident 3's AR, the AR indicated, Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including encounter for fitting and adjustment of urinary device and retention of urine, unspecified. During a review of Resident 3's H&P, dated 7/25/2025, timed at 2 PM, the H&P indicated, Resident 3 was able to answer, Yes or No, questions. The H&P indicated, Resident 3 had a past medical history of MRSA and Vancomycin Resistant Enterococcus (VRE - a type of bacteria causing healthcare-associated infections, resistant to the antibiotic Vancomycin), and UTI. During a review of Resident 3's MDS, dated 11/25/2025, the MDS indicated, Resident 3's cognitive skills for daily decision making was intact. During a concurrent observation and interview on 12/2/2025 at 10:11 AM with Certified Nurse Assistant (CNA) 2, used an eight (8) oz (ounce &ndash; a unit of volume) unlabeled, bottle of Perineal & Skin Cleanser Rinse Free and one half of the contents remaining was stored inside the first drawer of the PPE (Personal Protective Equipment &ndash; clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart located outside the room shared by Resident 7 and Resident 3. Resident 7 and Resident 3's room had an Enhanced Barrier Precautions (EBP &ndash; an infection control guideline for nursing homes that use gowns and gloves (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for high-contact care activities [like bathing, dressing, transfers] for residents with chronic wounds or indwelling devices or those colonized/infected with Multi-Drug Resistant Organisms (MDROs)) signage posted. CNA 2 stated, the skin cleanser should have been labeled with the resident name and not stored inside the PPE cart since the PPE was clean, the skin cleanser was classified dirty, to prevent the spread of germs, for infection control. During a concurrent observation and interview on 12/2/2025 at 10:23 AM with CNA 5, an unlabeled 12 Fl oz of Sea-Clens Wound cleanser was stored on top of the paper towel dispenser by the sink located outside of the restroom inside Resident 7 and Resident 3's room. CNA 5 stated, CNA 5 did not know why the wound cleanser was out since the wound cleanser looked like something that belongs to the Treatment Nurse (unidentified). CNA 5 stated, the wound cleanser should have been labeled and not left out since Resident 7 was ambulatory and might use the skin cleanser thinking the skin cleanser belonged to Resident 7. CNA 5 stated, the skin cleanser definitely should have been stored away, out of reach for safety and for infection control. During an interview on 12/3/2025 at 4:28 PM with the Infection Preventionist Nurse (IPN), the IPN stated, the skin cleanser should not be inside the PPE cart since the skin cleanser was not an equipment and especially that the room was on EBP and had two (2) residents. The IPN stated, the wound cleanser should have been labeled and stored at the resident's bedside for individual use so other residents would not get a hold of the wound cleanser to prevent cross contamination, for infection control. During a review of the facility 's policy and procedures (P&P) titled, Infection Prevention and Control Program, date revised July 2025, 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 and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. The facility failed to follow the facility's policy and procedure for Antibiotic Stewardship (offer providers and facilities a set of key principles to guide efforts to improve antibiotic use to effectively treat infections, protect patients from harms caused by unnecessary antibiotic use, and combat antimicrobial resistance) for 4 out of 5 sampled residents (Resident 13, 12, 51 and Resident 100). This deficient practice had the potential to result in inappropriate use of antibiotics that could lead to antibiotic resistance (occurs when bacteria, viruses, fungi and parasites no longer respond to antibiotics. As a result of drug resistance, antibiotics and other antimicrobial medicines become ineffective and infections become difficult or impossible to treat, increasing the risk of disease spread, severe illness, disability and death).During a concurrent review and interview on 12/5/2025 at 10:08 AM to 12:23 PM with the Infection Prevention Nurse (IPN). The IPN stated the facility was using McGeer's criteria (which defines the resident symptoms and other clinical criteria that are used to meet infection surveillance definitions. Infection surveillance definitions are essential for consistently monitoring infections over time and to determine where infection prevention efforts are needed. A log or line list can help organize information about resident infections). The following residents who were prescribed with antibiotics were reviewed. 1. During a review of Resident 51's admission Record (AR), the AR indicated the facility admitted Resident 51 on 10/11/25, with diagnoses that included urinary tract infection (UTI- infection of the kidney or bladder), metabolic encephalopathy (when a brain has trouble working because of a chemical or metabolic problem).During a review of Resident 51's Order Summary Report (OSR) from 11/1/25 to 11/30/25, the OSR indicated the following antibiotic orders:Administer Keflex (antibiotics used to treat infections) 500 milligrams (mg) two times a day for UTI/yeast infection for 5 days, order start date 11/5/25, order discontinued 11/6/25.Administer Ciprofloxacin (antibiotics used to treat infections) 500 mg two times a day for UTI for 7 days, order start date 11/10/25, completed.Cephalexin (antibiotics used to treat infections) 500 mg every 12 hours for UTI for 5 days, order start date 11/30/25.During a concurrent interview and review of Resident 51's Surveillance Data Collection Form (SDCF) for a urinary tract infection (UTI), with an indwelling catheter, the SDCF was incomplete. There was no information documented regarding Resident 51's signs and symptoms to indicate UTI and there was no information written or a print-out of Resident 51's urine culture result to indicate UTI. The IPN stated the IPN did not have the urine culture results, the laboratory (lab) would send an e-mail of resident's laboratory results, the IPN stated the IPN needed to print the lab results. During a concurrent review of Resident 51's Progress Notes (PN) dated 11/5/25 at 1:32 PM with the IPN, the IPN indicated Resident 51 complained of a slight burning when urinating. The IPN agreed when asked if the SDCF was completed upon the physician ordering the antibiotics. The SDCF would guide the licensed nurse what criteria to check for the use of antibiotics. During an interview, the IPN stated the criteria for the use of antibiotics could not be determined because there was no urine culture results. The IPN stated the IPN attempted to complete the SDCF but it was after the actual order. The IPN answered No when asked if the SDCF would serve it's purpose if completed after Resident 51 had completed the antibiotics. During a concurrent review of Resident 51's Microbiology, the urine culture result was dated 12/1/25. The IPN stated the IPN was not able to find the urine culture for November 2025. 2. During a review of Resident 12's AR, the AR indicated the facility admitted Resident 12 on 8/21/23, with diagnoses that included chronic kidney disease stage 4 (severe loss of kidney function), functional urinary incontinence (involuntary leakage of urine due to environmental or physical barriers to toileting).During a review of the facility's Order Listing Report (OLR), the OLR indicated the following antibiotic orders for Resident 12.Administer Amoxicillin 500 mg, two capsules by mouth every 8 hours for UTI, with a start date of 12/1/25 and discontinuation date of 12/3/25. During a concurrent review of Resident 12's SDCF for the use of Amoxicillin, the IPN stated Resident 12 did not have an indwelling catheter, the SDCF used was for a UTI with an indwelling catheter, the IPN stated the (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wrong SDCF was used. The SDCF indicated there was no information written regarding Resident 12's signs and symptoms to indicate UTI and there was no information written or a print-out of Resident 12's urine culture result to indicate a UTI. The IPN stated the IPN did not have the urine culture results and the laboratory (lab) would send an e-mail of resident's laboratory results. The IPN stated the IPN needed to print the lab results. During a concurrent review of Resident 12's Microbiology report, the urine culture result indicated a bacterial growth of enterococcus faecalis that is susceptible to ampicillin or Vancomycin. The antibiotic ordered for Resident 12 was Amoxicillin, the IPN stated the next step would be to call the physician to clarify the antibiotics ordered. 3. During a review of Resident 100's AR, the AR indicated the facility admitted Resident 100 on 11/26/25, with diagnoses that included metabolic encephalopathy and UTI. During a review of Resident 100's OSR, the OSR indicated an order for Cephalexin 500 mg, one tablet by mouth every 12 hours for UTI for 5 days, order start date 12/3/25 to 12/8/25. During a concurrent review of the SDCF, there was no SDCF completed. During a review of Resident 100's Progress Notes from 12/1/25 to 12/5/25 with the IPN, there was no documentation to indicate Resident 100 had signs and symptoms of UTI. During a review of Resident 100's urinalysis (U/A) dated 12/4/25, the U/A indicated there was no bacteria on the urine but there was positive blood and positive leukocyte esterase. During a follow-up interview, the IPN agreed there needed to be clarification of the antibiotics ordered and the physician needed to be notified of the current U/A result. The IPN agreed completing the SDCF would have guided the licensed nurse who received the order for antibiotics on what criteria to check for the use of antibiotics if the SDCF was completed upon receiving the order. 4. During a review of Resident 13's AR, the AR indicated the facility admitted Resident 13 on 11/17/25, with diagnoses that included history of falling, overactive bladder (sudden urges to urinate that may be hard to control). During a concurrent review of Resident 13's OSR and interview, the OSR indicated an order for Cephalexin 500 mg every 12 hours for infection for 5 days, order start date 11/17/25. The IPN stated the order was not clarified what was the infection being treated. During a review of Resident 13's SDCF, the SDCF did not specify the type of infection, the SDCF used for completion was for UTI with an indwelling catheter. There was no information written regarding Resident 12's signs and symptoms to indicate the infection and there was no information written or a print-out of Resident 12's culture results to indicate what type of infection was being treated. During an interview on 12/5/2025 at 11:41 AM, Licensed Vocational Nurse (LVN) 3 stated the process licensed nurses follow when receiving orders for antibiotics would be to complete the SDCF, that practice had not been continued and there was no reinforcement to continue due to the turnover of the IPN. LVN 3 stated completing the SDCF would be the responsibility of the desk nurse but there was no regular desk nurse. During a concurrent review of the facility's Policy and Procedure (P&P) titled Antibiotic Stewardship Program, the IPN stated No when asked if antibiotic time-out was practiced to review if antibiotic is indicated by reviewing signs and symptoms and laboratory results as indicated on the SDCF. The IPN stated No when asked if new admissions and readmissions were reviewed for appropriateness of antibiotic use if the laboratory results were not available for review. During a review of the facility's Policy and Procedure (P&P) titled Antibiotic Stewardship Program revised date 7/2025, the P&P indicated it is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The P&P indicated licensed nurses participate in the program through assessment of residents and following protocol established by the program. The P&P indicated monitoring of antibiotic use included the following: 1. Monitor response to antibiotics, and laboratory results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out). 2. Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. 3. Antibiotic orders obtained from consulting, specialty, or emergency providers shall be reviewed for appropriateness.		

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility offer influenza (FLU - is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness, and at times can lead to death) vaccine to two of five sampled residents (Resident 11 and Resident 20). This deficient practice had the potential to result in illness and physical declines to Resident 11 and Resident 20. Findings: a. During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted Resident 11 on 7/3/23 and readmitted the resident on 11/26/25, with diagnoses that included methicillin resistant staphylococcus aureus infection (MRSA - is a type of bacteria that many antibiotics don't work on), sepsis (infection of the bloodstream). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 12/3/25, the MDS indicated Resident 11 had severe cognitive (ability to think and make decisions) impairment, the MDS indicated Resident 11 did not receive influenza vaccine at the facility because Resident 11 declined the vaccine. b. During a review of Resident 20's AR, the AR indicated the facility admitted Resident 20 on 7/24/25 and readmitted the resident on 11/11/25, with diagnoses that included heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs), and pneumonia (lung infection). During a review of Resident 20's MDS, the MDS, dated [DATE] indicated Resident 20 had intact cognition. The MDS indicated Resident 20 did not get the influenza vaccine at the facility because it was offered and declined. During a review of the document titled 2025 vaccination on 12/5/25 at 12:31 with the Infection Prevention Nurse (IPN), the document indicated the following: Resident 11's influenza vaccination was administered on 10/28/24. Resident 20's influenza vaccination was administered on 2/18/25. During a review of Resident 11 and Resident 20's Vaccination Consent/Declination Form (VCD). There was no documented evidence indicating Resident 11 signed a VCD form. Resident 20's vaccination/declination form was dated 11/11/25, the VCD indicated Resident 20's resident representative declined the flu vaccine because Resident 20 had received the flu vaccine. During an interview on 12/5/25 at 12:46 PM, the IPN stated when residents (in general) consented or refuse vaccinations, the resident signed a consent/declination form as proof that education was provided regarding vaccination. The IPN stated Resident 11's vaccination consent/declination [for the current flu season] had not been completed. The IPN stated Resident 20's Flu vaccine was last flu season and would need to be provided information about the flu vaccine for the current flu season. During a review of the facility's Policy and Procedure (P&P) titled, Influenza Vaccination, revised date July 2025, the P&P indicated influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. Additionally, influenza vaccinations will be offered to residents upon availability of the seasonal vaccine until influenza is no longer circulating in the facility's geographic area. The P&P indicated the resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal. During a review of Center for Disease Control (CDC)'s publication titled, Recommendation for Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices, dated August 28, 2025, the publication indicated for most persons who require only 1 dose of influenza vaccine for the season, vaccination should ideally be offered during September or October. However, vaccination should continue after October and throughout the influenza season as long as influenza viruses are circulating and unexpired vaccine is available. During a review of the US Food and Drug Administration (FDA)'s publication titled, It's a Good Time To Get Your Flu Vaccine dated 1/31/25, the publication indicated the flu vaccine will trigger your immune system to produce antibodies to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protect against influenza disease, it will not make you sick with the flu. It can take about two weeks after vaccination for antibodies to develop in the body, which is an important reason to get your flu vaccine early, before flu activity starts.		

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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 Based on interview and record review, the facility failed to ensure a baseline care plan (CP) included administration of Lorazepam (a medication used to reduce anxiety [a feeling of worry, fear, or unease about future events] and agitation. A psychotropic drug [a substance that affects the mind, emotions, and behavior]), and Eliquis (anticoagulant, medication used to thin the blood and for clot prevention) for one of five sampled residents (Resident 98). This failure had the potential to result in uncoordinated care, no monitoring for adverse effects (unwanted, uncomfortable, or dangerous effects that a resident may have due to a medication) such as oversedation, increased fall risk, and bleeding complications. The absence of this information in the baseline CP could have led to delays in recognizing changes in condition, ineffective communication among the Interdisciplinary Team (IDT, a team of health care professionals who work together to establish plans of care for residents), and the potential to compromise Resident 98's safety. Findings: During a review of Resident 98's admission Record (AR), the AR indicated the facility admitted Resident 98 on 12/1/2025, with diagnoses including history of falls, anxiety disorder, and atrial fibrillation (a-fib, an irregular and often very rapid heart rhythm). During a review of Resident 98's baseline CP, dated 12/1/2025, the CP did not address Resident 98 was receiving Lorazepam or Eliquis. The CP's Section D indicated medications resident is taking a. psychotropic, f. anticoagulants, both sections were left blank. During a review of Resident 98's Brief Interview for Mental Status (BIMS) Evaluation, dated 12/2/2025, the BIMS indicated Resident 98's cognition (ability to understand and process information) was intact. During a review of Resident 98's Order Summary Report, dated active as of 12/3/2025. The OSR indicated: Lorazepam oral (taken by mouth) tablet 1mg (mg, unit of measurement), give 1 tablet by mouth every 24 hours PRN (as needed) for anxiety manifested by verbalizing feeling anxious, order date 12/1/2025. Eliquis oral tablet 2.5mg, give 1 tablet by mouth two times a day for clot prevention, order date 12/1/2025. During a concurrent interview and record review on 12/4/2025 at 01:07 PM, Resident 98's OSR dated 12/3/2025 and baseline CP dated 12/1/2025 were reviewed with Registered Nurse (RN) 1. RN 1 stated Resident 98 had a physician's order for Lorazepam PRN for anxiety and an order for Eliquis for clot prevention. RN 1 stated Resident 98's baseline CP did not indicate Resident 98 was receiving a psychotropic medication or an anticoagulant medication. RN 1 stated these medications should have been included in Resident 98's baseline CP to reflect the physician's orders dated 12/1/2025. RN 1 stated including these medications in the baseline CP was important to ensure staff were aware of the resident's medication needs, monitoring requirements, and associated risks during Resident 98's initial admission period. During an interview on 12/5/2025 at 12:57 PM, with the Director of Nursing (DON), the DON stated Resident 98's Lorazepam and Eliquis orders should have been included in the baseline CP. The DON stated these were high-risk medications, and their omission [in the CP] could have led to staff missing important monitoring needs such as sedation, behavior changes, or bleeding. The DON stated including these medications was essential to ensure coordinated care and early identification of potential complications during admission. During a review of the facility's Policy and Procedure (P&P) titled, Baseline Care Plan revision dated 7/2025, 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 professional standards of quality care. The P&P indicated the baseline care plan will include the minimum healthcare information necessary to properly care for a resident including but not limited to: Initial goals based on admission orders, physician orders. dietary orders, therapy orders, and social services. The P&P indicated the admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. The P&P indicated once [the information was] gathered, initial goals shall be established that reflect the resident's stated goals and objectives.		

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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. Based on interview, and record review, the facility failed to develop and/or implement an individualized, person-centered comprehensive care plan (CP) that included measurable objectives, defined time frames, and specific interventions that addressed a diagnosis of dementia (a group of conditions, progressive state of decline in mental ability that interfere with daily activities) for 1 of 1 sampled resident (Resident 9). This deficient practice had the potential to result in Resident 9's cognitive (ability to understand and process information), behavioral, and safety needs not being properly identified, monitored, or addressed, which could lead to inadequate treatment, unmet needs, and a decline in Resident 9's overall well-being. Findings: During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted Resident 9 on 9/4/2024, with diagnoses including dementia, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety (a natural feeling of worry, fear, or unease about future events) disorder. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 9/5/2025, the MDS indicated Resident 9's cognition was moderately impaired. The MDS indicated Resident 9 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL, term used in healthcare that refers to self-care activities) and required partial/moderate assistance with mobility. During a review of Resident 9's CPs on 12/3/2025 at 1:22 PM, there was no documented evidence indicating a dementia-specific CP was developed for Resident 9. During an interview and a concurrent record review on 12/4/2025 at 12:57 PM, with Registered Nurse (RN) 1, Resident 9's CPs, were reviewed. RN 1 stated that a dementia-specific CP had not been developed, initiated, or implemented for Resident 9. RN 1 stated a dementia-specific CP should have addressed Resident 9's cognitive status, behavioral risks, communication needs, and safety concerns. RN 1 stated this was important because without a dementia CP, staff lacked clear guidance on how to manage Resident 9's cognitive and behavioral needs, which could have led to unmet needs, increased risk for functional decline, and inconsistent care [from staff]. During an interview on 12/5/2025 at 12:57 PM, with the Director of Nursing (DON), the DON stated that it was essential to create and implement an individualized, person-centered dementia CP that included measurable objectives, defined time frames, and targeted interventions that addressed the residents' cognitive needs. The DON stated a dementia-specific CP ensured staff had clear guidance on how to manage cognitive changes, prevent avoidable safety risks, and deliver consistent and appropriate care. The DON stated this supported resident safety, behavioral stability, and overall well-being. During a review of the facility's policy and procedure (P&P) titled Comprehensive Care Plans revision date 7/2025, the P&P's policy indicated this facility to develop and implement a comprehensive person-centered CP for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are identified in the resident's comprehensive assessment and to meet professional standards of quality.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide education of a new prescribed pain medication for one of five sampled residents (Resident 99) during medication administration on 12/4/2025. This deficient practice resulted in Resident 99 being uninformed regarding Resident 99's pain treatment and had the potential to result in medication errors to Resident 99. Findings: During a review of Resident 99's admission Record (AR), the AR indicated the facility admitted Resident 99 on 4/22/2021, with diagnoses that included wedge compression fracture of the second lumbar vertebrae (a break in the lower back bone), wedge compression fracture of T11-T12 (a break in the upper back bone). During a review of Resident 99's History and Physical (H&P), dated 12/5/2025, the H&P indicated Resident 99 had capacity to make decisions. During a concurrent observation and interview on 12/4/2025 at 8:33 AM, with Licensed Vocational Nurse (LVN) 2 and with Resident 99, LVN 2 administered Tramadol (medication used for the relieve moderate to severe pain) to Resident 99, LVN 2 stated here is your pain medication. Resident 99 stated Resident 99 usually took 2 pills for pain medication when Resident 99 asked for pain medication. Resident 99 asked LVN 2 what medication Resident 99 was taking and LVN 2 stated it was Tramadol. Resident 99 asked LVN 2 if Tramadol was a new medication and LVN 2 answered Resident 99, LVN 2 would check. During a concurrent interview on 12/4/2025 at 9 AM with LVN 2, LVN 2 stated Tramadol was a new prescribed medication for Resident 99. LVN 2 stated when a resident (in general) was administered a new medication, LVN 2 had to provide education regarding the name, dose, and potential side effects (unwanted or unintended effects caused by a medication) of the medication with the resident. During a review of Resident 99's Order Summary Report (OSR), dated active as of 12/5/2025, the OSR indicated a new order for Tramadol 50 milligrams (mg, unit of measurement) by mouth every 12 hours as needed for pain in the lower back, dated 12/3/2025. During a review of Resident 99's Medication Administration Record (MAR) for December 2025, the MAR indicated Tramadol was administered for the first time on 12/4/2025 at 8:33 AM. During a review of the facility's Policy and Procedure (P&P) titled Medication Administration revised July 2025, the P&P indicated medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. During a review of the facility's undated P&P titled Unnecessary Drugs, the P&P indicated residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a medication, the resident, family and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, in advance of such initiation or increase. The resident has the right to accept or decline the initiation or increase of a medication. This information will be documented in the medical record. During a review of a publication from the Agency for Healthcare Research and Quality (AHRQ) titled, Medication Administration Errors dated 3/12/2021, the publication indicated patient education is a core component of medication management. The publication indicated patients are educated routinely to ensure understanding of indication for therapy, intended outcomes and signs and symptoms of adverse events.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 11) received treatment and care in accordance with the facility's policy and procedure (P&P) titled, Intravenous Therapy, by failing to ensure Resident 11's need for a peripheral saline lock (S/L - a type of catheter placed intravenously [IV - within a vein] to administer medication or fluid into the bloodstream) access was assessed on 12/2/2025 and when Resident 11 had a PICC (Peripherally Inserted Central Catheter - a long thin tube inserted into a vein in the upper arm and threaded to a large central vein near the heart, used for long term IV fluids, medications, nutrition, blood transfusion and drawing blood avoiding repeated needle sticks). Additionally, the facility failed to ensure Resident 11's S/L site remained clean and Resident 11's PICC was dated. This deficient practice resulted in redness in Resident 11's S/L site on Resident 11's right wrist and Resident 11 complaining of pain in his right arm. The deficient practice had the potential to result in a physical decline to Resident 11. Findings: During a review of Resident 11's admission Record (AR), the AR indicated, Resident 11 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including unspecified abnormalities of gait and mobility (when a person is unable to walk in a typical way) and repeated falls. During a review of Resident 11's undated History and Physical (H&P), the H&P indicated, Resident 11 did not have decision making capacity. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 9/25/2025, the MDS indicated, Resident 11's cognitive skills (ability to think and process information) for daily decision making were moderately impaired. During a review of Resident 11's admission Assessment (AA), dated 11/26/2025 timed at 1:20 P.M. the AA indicated Resident 11 had a PICC Line IV access in the left antecubital (triangular area at the front of the elbow). The AA did not indicate the presence of a S/L. During a review of Resident 11's Skin Only Evaluation ([NAME]), dated 11/27/2025, timed at 1:50 PM, the [NAME] did not indicate the presence of a PICC or S/L. The [NAME] indicated Resident 11 was currently on Vanco (Vancomycin - a type of antibiotic used to treat serious infections) IV. During a review of Resident 11's Order Summary Report (OSR), active orders as of 12/2/2025, the OSR indicated an order dated 11/29/2025 to monitor IV site, if a problem, document corresponding code: R=Redness, S=Swelling, B=Bleeding, P=Pain, D=Discharge, L=Leaking, O=Out every shift for site maintenance. During an observation on 12/2/2025 at 9:48 AM, Resident 11 was lying in bed. Resident 11 had a covered S/L in his right wrist with a wrapped around old (stained light brown around the S/L port) looking multiple layers of kerlix dressing (a sterile or clean protective covering) around the S/L port. Resident 11's skin had slight redness above and below the dressing site. Resident 11 had a double lumen (channel or port) PICC line in his left upper arm that had an intact, undated Opsite (name brand) dressing. At Resident 11's bedside, there was an IV infusion pump with an empty bottle of Vancomycin one gram (unit of measurement) IV. During a concurrent observation and interview on 12/2/2025 at 4:13 PM with the Director of Nursing (DON), Resident 11 was lying in bed complaining of right arm pain. The DON stated Resident 11 was admitted to the facility with the IV lines, I don't know why the hospital said to keep it [S/L]. The DON stated the PICC dressing should have a date, if not, [the dressing had to be] replaced and dated (PICC). The DON was asked by the surveyor to remove the kerlix wrap dressing to check the site. The S/L site had a clear dressing dated 11/20/25 and there was redness around the IV site extending below and above the IV site. The DON stated staff should have checked [the IV site]. The DON stated the DON was going to remove the S/L, right away. During an interview on 12/4/2025 at 8:42 AM with Registered Nurse Supervisor (RN) 1, RN 1 stated when a resident (in general) was admitted with a S/L and a PICC, RN 1 would remove the S/L if there was no need for the S/L; otherwise, RN 1 would change the bandage if there was a need for the S/L. RN 1 stated, Resident 11's S/L dressing was tattered, and Resident 11 looked like Resident 11 had phlebitis (inflammation of the walls of the veins can be caused by vein (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trauma from the IV catheter), starting to look red around it. RN 1 stated, RN 1 would have removed the dressing to check the site for redness, swelling, heat, and any signs of infection. RN 1 stated, the S/L should have been removed if there was no strong justification to keep the S/L since Resident 11 had a PICC. During a review of the facility's P&P titled, Intravenous Therapy, date revised July 2025, the P&P indicated, IV sites were changed every seventy-two (72) hours unless otherwise ordered by the physician, if the site becomes infiltrated, or if the resident exhibited signs and symptoms of phlebitis. In the event an IV is left in place longer than 72 hours, IV site care would be done every twenty-four (24) hours.		