STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridge Valley Center for Nursing and Rehabilitation	1000 College Street Wilkesboro, NC 28697

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38515 Based on record review and staff and resident interviews, the facility failed to treat a resident with respect and dignity when Nurse #3 told a resident (Resident #48) that he would not be sent out to the hospital after he yelled that he was uncomfortable and felt that no one was helping him. The facility also failed to treat a resident with respect and dignity when the facility failed to address unwanted facial hair on a resident (Resident #20) This was for 2 of 6 residents reviewed for treating residents with respect and dignity. The findings included: 1. Resident #48 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder, paraplegia, and chronic pain syndrome. A review of Resident #48's quarterly Minimum Data Set assessment dated [DATE] revealed Resident #48 was cognitively intact with no delusions, behaviors, or rejection of care. During an interview with Resident #48 on 09/04/24 at 2:15 PM revealed he had been feeling bad on 08/21/24 with some pain in his upper back. Resident #48 reported he was seen by the Physician Assistant (PA) #1 earlier in the day who prescribed him some medication that she thought would help. He stated the day progressed and in the early evening he started to have worsening discomfort not just in his back but also in his chest accompanied by some shortness of breath. He reported he rang his call light, and Nurse Aide (NA) #5 came in his room and checked on him. He stated he told NA #5 about his worsening chest pain and shortness of breath, and she told him she would immediately go tell his nurse (Nurse #3). Resident #48 called 911. Resident #48 reported once he hung up with 911, Nurse #3 came to the room. He reported he was scared and hurting and yelled stating his chest was tight and that he was not ok. Resident #48 admitted he was loud in his communication with Nurse #3 but insisted it was due to him being scared. Resident #48 reported Nurse #3 responded by telling him he was not going to speak to her like that and that she would not send him out and he could just sit there. Resident #48 reported the interaction made him feel like he did not matter and was afraid that he would not get the help he felt he needed. Resident #48 reported after the interaction, Nurse #3 left his room, and he decided he would call 911 again. Resident #48 reported when he spoke with the 911 operator, he told them he was not ok and was having chest discomfort and shortness of breath. Resident #48 stated Emergency Medical Services (EMS) did arrive shortly after and took him to the hospital. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #5 was conducted on 09/04/24 at 2:57 PM revealed she could not recall how she ended up in Resident #48's room on the evening of 08/21/24 but stated he reported to her that he was hurting badly in his back and chest. NA #5 reported Resident #48 appeared red-faced during this interaction, and she immediately left his room and went and reported Resident #48's condition and his request to go to the hospital to Nurse #3. NA #5 reported Nurse #3 was at the nurse's station at that time and told her that she would go down to Resident #48's room. NA #5 also stated she remembered hearing some conversation between Resident #48 and Nurse #3 while she was in a room across the hall but stated she could not make out what they were talking about. NA #5 reported EMS did arrive at the facility after she took Resident #48's vital signs and transported him to the hospital. An interview with Nurse #3 on 09/04/24 at 2:37 PM revealed she was the nurse assigned to Resident #48 on 08/21/24. She reported she was aware that Resident #48 had been seen by PA #1 earlier in the day for some pain in his back. She stated later in the day she was made aware by NA #5 that Resident #48 was complaining of pain. She stated she when she went down to the room to check on him, Resident #48 was agitated and was complaining of heaviness in his chest. She reported when she was trying to speak to Resident #48 about his complaints, he was very agitated and began beating on his chest and yelling no one here will help me! Nurse #3 reported at that point, she decided to remove herself from the room and asked NA #5 to get his vital signs. Nurse #3 insisted she never told Resident #48 that she would not send him out and that he was fine. She also indicated she felt her interactions with Resident #48 remained respectful throughout. Nurse #3 insisted that after she left Resident #48's room, she contacted the on-call provider and received an order to send Resident #48 to the hospital. She also reported she contacted EMS via telephone and requested them to come transfer Resident #48 to the hospital. An interview with the DON on 09/06/24 at 12:23 PM revealed she was not in the facility at the time of the incident but stated she was aware that Resident #48 had called EMS for assistance on the evening of 08/21/24. She reported Resident #48 did not have a history of behaviors and was cognitively intact. The DON reported Resident #48 had been seen earlier in the day by PA #1 for some mild upper back pain. The DON stated it did not matter if a resident was agitated, combative, or rude, he should have been treated with respect and understanding and that Nurse #3 should have never told him he was fine and he was not going to be sent out if Resident #48 was in pain or was requesting to be transferred. An interview with the Administrator on 09/06/24 at 2:55 PM revealed she was aware of the incident and that she was familiar with Resident #48. She reported Resident #48 did not have a history of behaviors and was cognitively intact. She reported she expected her staff to treat all residents with respect and dignity and she would have expected Nurse #3 to speak to Resident #48 in a respectful and dignified manner while trying to calm him down and reassure him that he would be taken care of. 37280 2. Resident #20 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact and required substantial to maximal assistance of one staff for personal hygiene which included shaving. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/03/24 at 12:48 PM an observation and interview were made of Resident #20 who was lying in her bed. The Resident was noted to have black and gray hairs approximately one eighth of an inch long that covered her chin and neck. Resident #20 was asked about the hairs and the Resident stated she got a bed bath on Sunday 09/01/24, (her choice) and if she did not request to be shaved, then she would not be shaved by staff. She stated she did not know why she was not shaved on Sunday 09/01/24. Resident #20 voiced the last time she was shaved was her last bed bath on 08/25/24. When the Resident was asked about her facial hair, she hid her face with her right hand and explained her facial hair grew fast and it was embarrassing to her. She stated she always shaved her facial hair to prevent the growth of a beard and while shielding her face with her hand she explained that it made her feel lesser of a woman. An observation was made on 09/04/24 at 9:15 AM of Resident #20 lying in bed sleeping. The facial hair remained unchanged. On 09/04/24 at 3:18 PM an interview was conducted with Nurse Aide (NA) #5 who explained that Resident #20 was alert and oriented and voiced her wants and needs. The NA continued to explain that he was assigned to Resident #20 on both Saturday 08/31/24 and Sunday 09/01/24 and received assistance of 2 other staff to provide the Resident's scheduled bed bath on Sunday. The NA stated that he first noticed the Resident's facial hair on Saturday (08/31/24), and he told Resident #20 on both Saturday and Sunday that he would shave her but there were no razors available to shave her with. The NA remarked that Resident #20 asked to be shaved on Sunday during her bed bath, but he knew there were no razors to shave her with. An interview was conducted with the Central Supply Clerk on 09/04/24 at 4:09 PM. The Central Supply Clerk explained that she was responsible for ordering medical supplies and she obtained the inventory and ordered the supplies once a week on Tuesday and the supplies arrived at the facility on Friday. She continued to explain that occasionally the delivery truck did not make the delivery on Friday and would usually come on the following Monday but the past Monday, 09/02/24 was a holiday and the delivery truck was delayed. The Central Supply Clerk confirmed there were no razors available to be used over the weekend and the Administrator obtained razors at a local store on Monday 09/02/24. An observation was made of Resident #20 on 09/05/24 at 11:00 AM. The Resident was noted to be clean shaven, and the Resident smiled and stated, thank you. On 09/06/24 at 2:39 PM an interview was conducted with the Administrator who confirmed she obtained razors from a local store on Monday 09/02/24 when she was notified that there were no razors in the facility. She indicated not being able to shave a resident because of running out of razors was unacceptable and they would have to review the system on how supplies were ordered to prevent that from happening again.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280 Based on observations, record reviews and resident and staff interviews, the facility failed to trim a dependent female resident's facial hair for 1 of 6 residents (Resident #20) reviewed for activities of daily living (ADL). The finding included: Resident #20 was admitted to the facility on [DATE] with diagnoses that included heart failure, diabetes mellitus, chronic obstructive pulmonary disease and respiratory failure. A review of Resident #20's care plan revised 06/19/23 revealed the Resident had a self-care ADL deficit related to decreased mobility and disease process. The goal to maintain her current level of function would be attained by utilizing interventions which included providing extensive assistance of one staff with personal hygiene (shaving). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 was cognitively intact and required substantial to maximal assistance of one staff for personal hygiene which included shaving. There was no documentation on the MDS that indicated Resident #20 rejected care. On 09/03/24 at 12:48 PM an observation and interview were made of Resident #20 who was lying in her bed. The Resident was noted to have facial hair that covered her chin and neck. Resident #20 explained that she received a bed bath on Sunday (09/01/24) and did not get a shaved even after she requested to be shaved. The Resident indicated she had to request to be shaved when she was given a bed bath otherwise, she would not be given a shave. Resident #20 stated she did not know why she did not get a shave on Sunday. An observation was made on 09/04/24 at 9:15 AM of Resident #20 lying in bed sleeping. The facial hair remained unchanged. An interview and observation were made with Resident #20 on 09/04/24 at 3:11 PM. The Resident explained that she received a bed bath once a week on Sunday and usually got a shave on the same day. Resident #20 still had a facial hair during the interview. On 09/04/24 at 3:18 PM an interview was conducted with Nurse Aide (NA) #5 who explained that Resident #20 was alert and oriented and voiced her wants and needs. The NA continued to explain that he was assigned to Resident #20 on both Saturday 08/31/24 and Sunday 09/01/24 and received assistance of 2 other staff to provide the Resident's scheduled bed bath on Sunday 09/01/24. The NA stated that he noticed the Resident's facial hair on Saturday 08/31/24, and he told Resident #20 on both Saturday and Sunday that he would shave her but there were no razors available to shave her with. He indicated he looked in the shower room and the central supply room on both days and there were no razors available to use. NA #5 stated Resident #20 does not refuse her bed baths or her shaves. At 09/04/24 at 4:00 PM NA #5 was accompanied to the central supply room to locate razors and there were several packages of razors in a bag labeled with a local store brand. The NA explained that the bag of razors was not in the central supply room on Saturday or Sunday. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Central Supply Clerk on 09/04/24 at 4:09 PM. The Clerk explained that she was responsible for ordering medical supplies and she obtained the inventory and ordered the supplies once a week on Tuesday and the supplies arrived at the facility on Friday. She continued to explain that occasionally the delivery truck did not make the delivery on Friday and would usually come on the following Monday but the past Monday 09/02/24 was a holiday therefore, the delivery truck was delayed. The Clerk confirmed there were no razors available to be used over the weekend and stated she learned that they ran out of razors on Monday when the Administrator obtained razors at a local store. The Clerk indicated she should have thought to get razors when the delivery truck did not come Friday but she did not think of it. On 09/06/24 at 2:39 PM an interview was conducted with the Administrator who confirmed she obtained razors from a local store on Monday 09/02/24 when she was notified that there were no razors in the facility. She indicated it was unacceptable to run out of razors.

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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** 35789 Based on record review, staff, and Nurse Practitioner interviews the facility failed to assess Resident #125 before transferring him back to bed after he was found on the floor for 1 of 2 residents reviewed for falls. The findings included: Resident #125 was admitted to the facility on [DATE] and expired on [DATE]. Resident #125's diagnoses included malignant neoplasm of lung and skin, and anxiety. The admission Minimum Data Set (MDS) dated [DATE] revealed that Resident #125 was cognitively intact and required supervision with transfers. There was no behaviors or rejection of care noted during the assessment reference period. There was also no history of falls in the 6 months prior to admission or since admission to the facility. The MDS also revealed that Resident #125 had a prognosis of less than 6 months to live and received hospice care. Review of an initial allegation report dated [DATE] at 4:25 AM read, staff reported that Nurse Aide (NA) #2 handled Resident #125 roughly during the provision of care. The initial allegation report was completed by Former Administrator #1. NA #2 was interviewed via phone on [DATE] at 11:40 AM. NA #2 confirmed that she was working the night shift on [DATE]. She stated she was walking past Resident #125's room and found him lying flat on the floor with urine all around him. NA #2 stated she requested assistance from the nurse but could not recall who that was, but no one came to the room for a while. NA #2 stated that while she was in Resident #125's room waiting for other staff to assist she went ahead and got Resident #125 off the floor and back into bed and was in the process of getting him cleaned up when NA #3 and NA #4 came in to assist. NA #2 stated that she alerted the nurse and when she did not show up in the room, she assumed it was okay to get Resident #125 back into the bed because the nurse was aware that he was on the floor. Again NA #2 could not recall which nurse she reported to. NA #3 was interviewed via phone on [DATE] at 2:43 PM. NA #3 confirmed that she was working the night shift on [DATE] along with NA #2 and NA #4. NA #3 stated she recalled that she, NA #2 and NA #4 were in Resident #125's room and NA #2 had assisted Resident #125 from the floor to the bed after NA #3 and NA #4 had changed the sheets on the bed. NA #2 had reported to NA #3 and #4 that Nurse #3 was aware that Resident #125 was on the floor. NA #3 stated she did not recall Nurse #3 being in the room before NA #2 transferred him from the floor back to bed but stated but they were aware we moved him. Attempts to speak to NA #4 were made on [DATE] and [DATE] and were unsuccessful. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A handwritten statement from NA #4 dated [DATE] read in part, I answered the call bell for {Resident #125} and when I entered the room, I noticed that he was half on and half off the bed in a praying stance. He was very confused and disoriented. I called for help and {NA #2 and NA #3} entered the room. {NA #2} began to try to assist the resident up out of the floor. In his given condition, he was unable to do so. {NA #2} ended up transferring the resident by herself without waiting for {NA #3} or myself to help. Once the resident was on the bed, I stayed with the resident while {NA #3} went and got our nurse. The statement was signed by NA #4. Nurse #2 was interviewed via phone on [DATE] at 12:10 PM who confirmed that she was working the night shift on [DATE]. She stated she was on the phone with hospice trying to get something for Resident #125 when NA #2 approached her about something. Because she was on the phone NA #2 went and got Nurse #3 but after the phone call was over Nurse #2 stated she went and got the rundown of what had occurred. It was reported that Resident #125 had fallen, and they got him back to the bed without being assessed. Nurse #2 stated that it was not reported to her that Resident #125 had fallen until after NA #2 had transferred him back to bed. She stated when she found out she did go and assess Resident #125 for injuries and range of motion but could not identify any injuries sustained from the fall. Nurse #3 was interviewed via phone on [DATE] at 3:17 PM who confirmed that she was working the night shift on [DATE]. Nurse #3 stated that she was unaware that Resident #125 had fallen, or that NA #2 had transferred him back to bed until after Resident #125 was back in the bed. Nurse #3 stated that she and Nurse #2 went to Resident #125's room and Nurse #2 assessed him to have no injuries from the fall. The Nurse Practitioner was interviewed on [DATE] at 8:35 AM who stated that any resident that had a fall should be assessed by a nurse for injury before being moved. The Director of Nursing was interviewed on [DATE] at 11:56 AM. The DON stated that she was unaware that Resident #125 had fall on the night of [DATE]. She stated when a resident had a fall they have to be assessed by a nurse before being moved. The NAs should never get anyone up including Resident #125 without an assessment from the nurse. Once the nurse assessed the resident and deemed it safe to move the resident then the resident can be assisted back to bed or chair.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045 Based on record review, Resident, and staff interviews, the facility failed to assess a resident for pain on admission and when there was a change in condition for 1 of 3 residents reviewed for pain management (Resident # 88). The findings included: Resident #88 was admitted to the facility on [DATE] with diagnoses which included a left femur (long bone in the upper leg) fracture (break), sternal body (breastbone) fracture, liver laceration (trauma to the liver that causes bleeding), L1 vertebral body (spinal bone in the lower portion of the back) fracture, right forehead laceration (tear), and metacarpal (hand bone) fractures. A review of an admission nurse's note, authored by Nurse # 3, dated 6/14/2024 revealed Resident #88 had arrived at the facility via Emergency Medical Services (EMS), was pleasant, and alert and oriented. Resident #88 had extensive bruising and staples in his left leg and had a femur fracture. Resident #88 had staples on his right forehead and had a cast on his right arm. Resident #88 reported he had been in a motorcycle crash and sustained injuries. Resident #88 was wearing a two piece back brace. An interview was conducted on 9/4/2024 at 3:11 pm with Nurse #3. Nurse #3 stated she admitted Resident #88 to the facility on [DATE]. Nurse #3 stated Resident #88 was pleasant when he arrived at the facility and was placed in a room on one side of the building, but had requested a room change shortly after he arrived. Nurse #3 stated she moved Resident #88 to his new room and was unsure if she assessed his pain on admission. A review of Resident #88's Electronic Health Record (EHR) revealed there was no pain assessments documented on 6/14/2024. A review of the physician's orders dated 6/14/2024 revealed orders for Resident #88 to receive Hydrocodone-Acetaminophen (pain medication) 5-325 milligrams (mg) by mouth every 6 hours as needed for moderate (4-6 out of 10 on the numerical pain scale) pain or severe (7-10 out of 10 on the numerical pain scale) pain for 7 days, Tramadol (pain medication) 50 mg by mouth every 6 hours as needed for back pain for 5 days, and Acetaminophen 325 mg by mouth every 6 hours as needed for mild (1-3 out of 10 on the numerical pain scale) pain for 10 days. A review of Resident #88's Medication Administration revealed Resident #88 had not received any medications on 6/14/2024. A review of the medication count from the medication dispensing machine dated 6/14/2024 revealed the facility had a total of 6 tablets of Tramadol 50 mg tablets on hand. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 9/6/2024 with Nurse Aide (NA) #6. NA #6 stated she worked first shift (7:00 am to 7:00 pm) and stated she was assigned Resident #88 on 6/14/2024. NA #6 stated Resident #88 was initially placed in a room on another hall and transferred to her hall soon after his arrival due to an issue with the air conditioning. NA #6 stated he was frustrated and upset because he was in pain and requested pain medication. NA #6 stated she told Nurse #5 that Resident #88 was in pain wanted pain medication. NA #6 stated Nurse #5 told her Resident #88's pain medication had not arrived. NA #6 stated he was upset the remainder of her shift and had not received any pain medication. An interview was conducted on 9/6/2024 at 11:53 am with Nurse #5. Nurse #5 stated she worked first shift (7:00 am to 7:00 pm) and was assigned Resident #88 on 6/14/2024. Nurse #5 stated Resident #88 was originally placed in a room on another hall and then transferred to her hall. Nurse #5 stated Nurse #3 told her Resident #88's admission had been completed. Nurse #5 stated she did not assess Resident #88 for pain because she was under the impression given by Nurse #3 that there were no needs/issues. Nurse #5 stated she did not recall NA #6 reporting Resident #88 being in pain to her during her shift. A review of a late entry nursing progress note dated 6/15/2024, authored by Nurse #4, revealed Resident #88 approached Nurse #4 in the hallway and requested to be sent to the hospital at which time he stated, I'm having chest pains. Resident #88's blood pressure was 206/135, heart rate was 87 beats per minute, respiration rate was 18 breaths per minute, and oxygen saturation level was 94% on room air (not on oxygen). Nurse #4 contacted the on-call provider and Director of Nursing (DON) and Resident #88 was sent to the Emergency Department. A review of the Emergency Medical Services (EMS) report dated 6/14/2024 revealed EMS was dispatched to the facility at 9:42 pm in reference to chest pain (non-cardiac) and hypertension. Upon arrival Resident #88 was found in bed, alert and oriented. Resident #88 had an initial blood pressure of 186/111, a heart rate of 82 beats per minute (normal is 60-100 beats per minute), a respiration rate of 18 breaths per minute (normal is 12-20 breaths per minute), and an oxygen saturation level of 97% (normal is greater than 92%) on room air. Resident #88 rated his pain as a 2 out of 10 (mild) on the numerical pain scale and did not receive any medications from EMS. Resident #88 was transported to the hospital and remained pleasant and talkative throughout the transport. A review of the Emergency Department documentation dated 6/14/2024 revealed Resident #88 arrived in the Emergency Department with chest pain and reported the facility wanted him to stay in bed all day until he was evaluated and not given him any pain medication since he had arrived at the facility. Resident #88 reported he did not want to return to the facility. Resident #88 received Morphine (pain medication) 4 milligrams (mg) intravenously and was admitted to the hospital for malignant hypertension (an elevated blood pressure accompanied by multiple complications). Resident #88 was discharged home from the hospital on 6/19/2024. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 9/6/2024 at 11:22 am with Resident #88. Resident #88 stated he arrived at the facility on a Friday afternoon after he was discharged from the hospital following a motorcycle accident. Resident #88 stated he was in pain when he arrived at the facility, and reported his pain was a 9-10 out of 10 on the numerical pain scale. Resident #88 stated he had back and leg pain. Resident #88 stated he had told a NA (unable to remember who), that he was in pain and requested pain medication. Resident #88 stated he was told the facility did not have his medication. Resident #88 stated the pain continued into the night, at which point he started to develop chest pains. Resident #88 stated he told the nurse he was having chest pain and wanted his vital signs checked. Resident #88 stated after he saw how high his blood pressure was, he demanded to go to the hospital. Resident #88 stated when he arrived at the hospital, he was given pain medication and later admitted . An interview was conducted on 9/6/2024 at 11:36 am with the Medical Director (MD). The MD stated she was not employed by the facility on 6/14/2024. The MD stated when a resident was admitted to the facility, the staff should assess for pain at that time and whenever the resident expressed that they were experiencing pain. An interview was conducted on 9/6/2024 at 1:16 pm with the DON. The DON stated she was on leave at the time Resident #88 was admitted to the facility. The DON stated a pain assessment should have been performed on admission. An interview was conducted with the former Interim DON. The former Interim DON stated she was present at the facility on 6/14/2024 when Resident #88 arrived. The former Interim DON stated he was initially on one hall and had to be moved to another hall. The former Interim DON stated when Resident #88 arrived at the facility he was smiling and conversating with other residents. The former Interim DON stated after he switched rooms, his mood changed, and he became aggravated and wanted to leave. The former Interim DON stated Resident #88 never mentioned being in pain and did not appear to be in pain while she was at the facility. The former Interim DON stated a pain assessment should be performed on admission and when changes occurred and was not sure why there was no pain assessment documented for Resident #88.