STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Manor	222 Parkview St Plymouth, IN 46563

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review and interview, the facility failed to implement preventative measures for 1 of 3 residents at risk for elopement which resulted in a resident elopement. (Resident B) Finding includes:During an observation and interview, on 4/15/2026 at 9:49 A.M., Resident B was in his room, seated in his wheelchair with his portable oxygen nasal cannula tubing in the top drawer of his bedside table. Resident B was unable to determine where his oxygen cannula tubing was located. He also had an animated dog on his bed and was speaking to the animated dog about his feelings. A record review for Resident B was completed, on 4/15/2026 at 9:54 A.M. Diagnoses included, but were not limited to: dementia and a pathological fracture in neoplastic disease of the hip An Elopement/Wander Risk Evaluation, completed on 3/11/2026, indicated Resident B had been forgetful, had a short attention span and exhibited/expressed fear/anxiety, expressed a desire to go home and packed belongings or hovered at exit doors. The note indicated, around 7:30 P.M., Resident B had wanted to go home with his kids, removed his gown and oxygen nasal cannula and attempted to move the bedside table. An admission Minimum Data Set (MDS) assessment, dated 3/16/2026, indicated Resident B had severe cognitive impairment. A Care Plan, initiated on 3/11/2026 and revised on 3/19/2026, indicated Resident B's was an elopement risk/wander as evidenced by wandering/exit seeking. Interventions included, but were not limited to: distract Resident B from wandering by offering pleasant diversions, structured activities, food, conversation, television and books and provide structured activities including toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. A Nursing Progress Note, on 3/12/2026 at 12:03 A.M., indicated Resident B stated he was going home because no one was taking care of his children. Resident B firmly believed he needed to go home. Resident B became agitated when staff provided reassurance of the children being okay and stated, I don't want you to tell me they are okay, I want to go and see them. No further behaviors observed of eloping or getting out noted. Staff continued to check on Resident B frequently. A Nursing Progress Note, on 3/12/2026 at 3:31 P.M., indicated sundowning behavior at evening shift noted with reassurance, one to one conversation with staff and safety provided at all times. A Nursing Progress Note, on 3/15/2026 at 6:36 P.M., indicated Resident had been engaging in wandering behaviors, but easily redirected. A Nursing Progress Note, on 3/23/2026 at 6:45 P.M., indicated Resident B had intermittent confusion and anxious complaints concerning the safety of his daughters. A Nursing Progress Note, on 3/24/2026 at 10:38 A.M., indicated intermittent confusion in the morning. Resident B indicated, Can you look to see if my mother is here, I believe she is in this hospital. A Nursing Progress Note, on 3/25/2026 at 1:37 A.M., indicated Resident B had been observed on the East Hall (room was on [NAME] Hall) upon arriving for the shift and had been difficult to redirect to his room. A Nursing Progress Note, on 3/26/2026 at 4:15 P.M. and 11:03 P.M., indicated Resident B had intermittent confusion and had been concerned about his car. A Nursing Progress Note, on 3/28/2026 at 9:00 P.M., indicated Resident B had been observed outside of the facility and had exhibited chronic and persistent confusion. A Nursing Progress Note, on 3/28/2026 at 10:31 P.M. as a late entry on 4/4/2026 at 6:35 P.M., indicated an Elopement Risk Assessment had been completed and a Wander guard (a wearable bracelet with a door sensor system (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to provide staff alerts when breaching a door) had been placed in the back pocket of Resident B's wheelchair. A Facility Reportable Incident, with a identified time of incident of 3/28/2026 at 8:50 P.M., indicated a Licensed Professional Nurse (LPN) reported to the Executive Director that Resident B had left the facility unattended. The Executive Director initiated an investigation and reviewed the facility's camera footage. Resident B had been observed exiting the facility and was outside for four minutes and 14 seconds. Prior to the elopement, Resident B had been observed, on the camera footage, self-propelling his wheelchair within sight of facility staff members and not trying to exit the building. At 8:43 P.M., Resident was observed self-propelling down the hallway. He exited the facility at 8:46 P.M. Resident B had been observed on the camera footage re entering the building at 8:51 P.M. Resident B indicated he had been looking for his daughters and his truck. An Employee Statement, dated 3/29/2026, indicated QMA 2 had brought Resident B back to his residing hallway twice prior to the elopement. She indicated the first time Resident B had tried to leave through the back doors by the dietary department, and a cook brought Resident B back around at 8:45 P.M. Education had been provided to Resident B without success. Resident B requested to call his daughter and spoke with her via the telephone. Resident B then attempted to exit the doors at the end of his residing hallway and had been redirected. QMA 2 indicated the Certified Nursing Assistant (CNA) for the hallway was at lunch and QMA 2 had been in another resident room when Resident B had eloped and a CNA from another hallway returned the resident to his hall. An Employee Statement, on 3/29/2026 at 1:09 P.M., indicated LPN 3 had been notified by a CNA that Resident B had been observed outside of the building in the parking lot. LPN 3 indicated she had been notified that Resident B had not been wearing a Wander guard at the time. LPN 3 indicated she personally observed the CNA bring Resident B back into the facility. LPN 3 indicated she had observed Resident B propelling himself up and down various hallways earlier during her shift and he had been looking for his daughters, but had been easily redirected. LPN 3 indicated she was not sure when the breach of the exit door had occurred or how long Resident B had been outside. During an interview, on 4/16/2026 at 10:04 A.M., the Executive Director indicated the door Resident B had eloped from had to be manually locked by the staff, otherwise it was unlocked. He indicated the door was usually locked by 9:00 P.M. He indicated an elopement risk assessment had been completed at admission for Resident B and the assessment had determined the basis as to the resident's elopement risk. If a resident was determined to be an elopement risk, the information was placed in the facility elopement risk binder with resident specific interventions that could include, but were not limited to a Wander guard. During an interview, on 4/16/2026 at 12:25 P.M., QMA 2 indicated she had not been aware that Resident B was an elopement risk. She indicated the dietary department had informed her that Resident B had been trying to exit the building around the dietary department. She indicated she had been questioned about his fifteen-minute checks, but there had been no paperwork indicating he was to be checked every fifteen minutes. QMA 2 indicated she was unaware that Resident B was to have been on fifteen-minutes checks. A policy was provided, on 4/16/2026 at 10:24 A.M, by the Executive Director. The policy titled, Elopement, indicted, .It is the policy of this facility to provide a safe and secure environment for our residents and to be proactive in preventing resident elopement. Residents at risk for elopement will be appropriately monitored to reduce the potential for injury. Elopement is defined as a resident leaving the premises of the facility without the knowledge and supervision of facility staff. 1. Upon admission, readmission, quarterly, and with a significant change of condition, residents will be assessed for elopement risk. 2. Residents that are identified as moderate or high risk for elopement will have an intervention implemented for their safety.4. Elopement risk will be care planned with individualized approaches to reduce the potential for elopement and/or to redirect the resident in the event that an elopement attempt is made. 5. Residents at moderate/high risk for elopement shall have their picture maintained for identification purposes. 6. Electronic monitoring systems may be implemented as possible interventions as appropriate. The past noncompliance began on 3/28/2026 at 8:43 P.M. when Resident B exited the facility unattended. The deficient practice was corrected on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/1/2026, prior to the start of the survey, after the facility implemented a systemic plan that included the following actions: Revision of elopement assessment and elopement care plan for Resident B, which included the implementation of a Wander guard bracelet placed on his wheelchair, a full facility re-evaluation of elopement risk assessments and review of all coordinating care plans, update and revision of the elopement risk binder, staff education regarding elopement risk and binder use and audits to ensure elope risk assessments were updated as required and the facility elopement risk binder was updated.This citation relates to Intake 2967439. 410 IAC 16.2-3.1-45(a)(2)