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	06/01/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview and record review, the facility failed to identify targeted behaviors and individualize interventions to clinically support the use of an antipsychotic and anti-depressant medications for 1 of 2 residents reviewed for chemical restraints (Resident E). Findings include:During intermittent observations on 6/1/26, from 10:00 A.M. to 4:00 P.M., Resident E was observed seated in her wheelchair, in the hallway across from the nurse's desk. Her face had a flat affect and she demonstrated no response to others as they passed by her. She did not seem to be sleepy or sedated but she was also unaware of her environment. The resident was not observed in any form of activity while seated in the hall. On 6/1/26 at 1:59 P.M., Resident E's record was reviewed. Diagnoses included but were not limited to: congestive heart failure, Alzheimer's dementia, neuromuscular dysfunction of the bladder, and parkinsonism (group of brain disorders which can cause tremors, slow movement, rigid muscles, and balance issues). Hospice progress notes, prior to admission, indicated the following: -Resident E had been receiving hospice services at home since 5/27/25. -On 6/16/25, the resident had been prescribed an anti-psychotic medication which was not part of her hospice plan of care. She was prescribed Olanzapine 2.5 milligram (mg)-1 tablet by mouth 2 times per day for behaviors/Alzheimer's. Per her hospice plan of care, she was prescribed Trazodone 50 mg-1 tablet by mouth for insomnia/restlessness. -A medical Social Service hospice note, dated 2/11/26, indicated Resident E's caregiver had reported since January 2026, the resident had become more confused and restless. She had behaviors of removing her clothes and incontinence products resulting in urinary accidents. An admission Minimum Data Set (MDS) assessment, dated 3/18/26, indicated the resident had severely impaired cognition, disorganized thinking, exhibited felling down in the past 7-11 days of the assessment time frame, had delusions, had exhibited physical behaviors toward others, and had exhibited 1-3 days of wandering in her wheelchair during the assessment time frame. The assessment indicated Resident E was prescribed anti-psychotic and anti-depressant medications. Review of the current care plans included the following: -Dated 3/18/26, Resident E had a behavior problem related to dementia. The goal was to not have evidence of behavior problems and have fewer episodes of physical/verbal behavior toward staff. Interventions included: administer medications as ordered and observe for/document side effects; be aware the resident does not get out of bed early except to go to the bathroom; staff should move slowly while leading her; provide activities which (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interested and accommodated her; and monitor behavior episodes and attempt to determine underlying cause-consider location, time of day, persons involved, and situations: document behavior and potential causes. -Dated 3/25/26, the resident used psychotropic medications related to behaviors. The goal was for the resident to not have side effects from the use of anti-psychotic medication. Interventions included: consult with pharmacy and physician to consider dosage reduction when clinically appropriate; monitor/record/report to physician, as needed, side effects of anti-psychotic medications which may include: tremors, confusion, restlessness, pacing, anxiety, dry mouth, blurred vision, constipation, low blood pressure, sedation/drowsiness, increased falls, appetite/weight changes, headache, insomnia, seizures, and urinary retention; observe for/record occurrence of target behavior symptoms and document per facility protocol. Current Physician orders, dated 3/12/26, included the following medication orders: 1. Olanzapine 2.5 mg-give 1 tablet by mouth 2 times per day for behaviors/Alzheimer's and 2. Trazodone 50 mg-give 1 tablet by mouth at bedtime for insomnia. A behavior note, dated 3/13/26 at 10:25 a.m., indicated Resident E was trying to get out of bed herself. When the Certified Nurse Aid (CNA) tried to help her, she had hit the CNA in the stomach, pulled the CNA's hair, and had thrown her orange juice at her. She had exhibited anxiety due to wanting to get out of bed and agitation because someone had attempted to help her. The note indicated Resident E was in a new setting and she had confusion due to her dementia. A Social Service Note dated 3/16/26 at 3:45 p.m., indicated during a phone discussion with the resident's Power of Attorney (POA), he had given his approval for the use of all psychotropic medications. The POA indicated Resident E was a different person without the anti-psychotic medications. He indicated she really had not had behaviors but was not cooperative (with care) when not on the medication. The Social Service note had not indicated the POA had been notified of the benefits, risks, and alternatives for the medications or possible side effects of their use. A Nursing progress note, dated 3/18/26 at 1:20 p.m., indicated an order was received for the resident to be seen by the in-house psychiatric services. A behavior progress note, dated 4/9/26 at 11:28 a.m., indicated a monthly behavior meeting had occurred with the pharmacist, psychiatric nurse practitioner (NP), unit manager and Social Services Designee (SSD). They had discussed the resident's use of antipsychotic medication and hospice services. Their recommendation was to continue the use of the antipsychotic medication, Olanzapine 2.5 mg 2 times per day and the hypnotic medication, Trazodone 50 mg at bedtime. The meeting note indicated they would re-evaluate the medication use the following month to consider a possible decrease in medication dosages. A behavior note, dated 5/10/26 at 4:33 a.m., indicated when a CNA had been attempting to change the resident, the resident had scowled at her, bared her fingernails, and said You'd better not b----. I've got talons and I can scratch your pretty face. The CNA was able to calm the resident and proceed with care. A nurse note, dated 5/10/26 at 4:15 p.m., indicated Resident E was acutely ill with a moist cough. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no other behaviors documented in the resident's record. Medication Administration Records (MAR), dated March 2026, April 2026, and May 2026, indicated the resident was administered Olanzapine 2.5 mg 2 times per day and Trazodone 50 mg at bedtime, as ordered on 3/12/26. The MARs for March, April, and May 2026, had not shown side effects of the medications had been monitored or documented. There were no targeted behaviors documented for the use of anti-psychotic and anti-depressant medications. There were no targeted behaviors documented for the use of anti-psychotic and anti-depressant medications or side effects of the medications in the progress notes. There was no documentation completed for monitoring the resident's sleep and insomnia. There were no records indicating Resident E had been seen by the psychiatric NP since admission to the facility. During an interview with the Social Services Director, on 6/1/26 at 4:11 P.M., she indicated residents who were prescribed psychotropic medications were to have targeted behaviors and interventions on the care plan and the MAR. She was unable to find targeted behaviors with interventions on the care plan or MAR for Resident E. When asked, she indicated documentation of behaviors was completed by the nurses in the nursing progress notes or behavior progress notes. She indicated the CNA's were not responsible for documenting behaviors in their task list. She indicated Resident E's care plan included that she was on psychotropic medications and side effects were to be monitored, but the side effect monitoring was not documented on the MAR. She indicated she had not notified the psychiatric NP of the order, dated 3/18/26, which had indicated the resident was to have been seen by the NP. She indicated it was missed. A current facility policy, titled Psychotropic Medication Use was provided by the Administrator on 6/1/26 at 4:59 P.M. which indicated: Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: a. determining adequate indications for use; b. establishing appropriate dose (including duplicate therapy) and duration; c. adequate monitoring for efficacy and adverse consequences; d. determining appropriateness of gradual dose reduction; and e. preventing, identifying, and responding to adverse consequences. Circumstances that warrant an evaluation of the resident's underlying medical condition and medications include: admission or readmission. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction.Adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on: an assessment of the resident's condition and therapeutic goals; a determination that non-pharmacological interventions are clinically contraindicated; and manufacturer's recommendations, clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that support the use of the medication. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: non-pharmacological alternatives; the indications and rationale for the recommendation; the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and the resident's/representative's right to accept or decline the treatment. Residents receiving psychotropic medication are monitored and the response to treatment is documented. Monitoring may include lab results, vital signs, progress notes, behavior flow sheets, medication administration records, and the drug regimen review from the consultant pharmacist. In addition, residents are monitored for adverse (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consequences associated with psychotropic medications. This Citation relates to Intake 3026032. 410 Indiana Administrative Code (IAC) 16.2-3.1-48(a)(3)(4)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 assess for the continued use of an indwelling urinary catheter, failed to monitor for UTI's, and failed to assess and monitor a resident's ability to urinate following removal of a urinary catheter for 1 of 1 residents reviewed (Resident E). Findings include:On 6/1/26 at 1:59 P.M., Resident E's record was reviewed. Diagnoses included but were not limited to: congestive heart failure, Alzheimer's dementia, and neuromuscular dysfunction of the bladder (nerve damage interrupts the communication between the brain and the bladder which is usually chronic). Review of Hospice progress notes, prior to admission to the facility, indicated the following: -A medical Social Service hospice note, dated 2/11/26, indicated Resident E's caregiver had reported she had started behaviors of removing her pants and pull-ups in the morning and not remembering doing so. The behavior had resulted in urinary accidents. The caregiver indicated she had spoken with the hospice nurse about the behavior. -A hospice care plan update, dated 2/13/26, indicated an indwelling catheter had been placed. -A hospice home visit progress note, dated 3/10/26, indicated during the visit, Resident E's indwelling catheter contained cloudy urine which was foul smelling. An antibiotic was started for urinary tract infection (UTI). -A Hospice Comprehensive Assessment and Plan of Care Update form, dated 3/11/26 at 4:11 p.m., indicated a list of diagnoses which had not included neurogenic bladder. The form indicated Resident E was incontinent and had an indwelling foley catheter which was draining well. An admission Minimum Data Set Assessment (MDS), dated [DATE], after the resident was admitted to the facility indicated the resident was severely cognitively impaired, had disorganized thinking, exhibited on 7-11 days of the asssessment time frame feeling down, exhibited delusions, exhbitied physical behaviors toward others, and on 1-3 days of the assessment time frame had exhibited wandering behavior in her wheelchair. in addition, Resident E required partial assistance with toilet transfers and toileting hygiene, had an indwelling urinary catheter for a diagnosis of a neurogenic bladder and was always incontinent of her bowels. The MDS assessment also indicated Resident E was receiving hospice services. The MDS had not indicated the resident had been admitted with a urinary tract infection. A Care Area Assessment for urinary incontinence and the use of the indwelling catheter, dated 3/20/26, had no documentation of Resident E's urinary tract infection, even though she had been treated with antibiotics from 3/12/26-3/17/26, and remained at risk for further UTI's related to the indwelling catheter use. A current care plan, revised on 3/20/26, indicated Resident E had an indwelling foley (urinary) catheter due to a diagnosis of a neurogenic bladder. The goal was for the resident to remain free from catheter-related trauma. Interventions were: The resident was to have an indwelling catheter which was to be positioned below the level of her bladder; staff were to check tubing for kinks each shift; monitor and document intake and output; and observe and document pain/discomfort related to the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter. There was no plan of care to address the resident's continued risk of UTI or interventions to prevent UTIs. Intermittent observations on 6/1/26, from 10:00 A.M. to 4:00 P.M., indicated Resident E had no foley catheter or foley catheter bag attached to her wheelchair. An admission history and physical form, dated 3/12/26, indicated Resident E had been admitted from home, on hospice services due to worsening debility. She was incontinent of her bladder. The form had not indicated Resident E had a diagnosis of neurogenic bladder nor was there documentation of an indwelling catheter being present. However, a physician's order, dated 3/17/26, indicated the resident was to have a 16 Fr (French-unit of measurement) foley (urinary) catheter with a 30cc (cubic centimeter) balloon with a drainage bag to gravity. The order included the following: May change as needed for leakage, dislodgement or as needed; Catheter care every shift; and monitor and record color and clarity of urine every shift. Nursing progress notes indicated the following: -3/16/26 at 7:06 p.m., the nurse had contacted the primary care physician to discuss the resident's foley catheter. A new order had been obtained to add the diagnosis of a neurogenic bladder. -3/21/26 at 11:18 p.m., Resident E was observed walking in her room holding onto her wheelchair. Staff intervened but during attempts to assist the resident to sit back down, she had pulled her catheter tubing out. She had mild bleeding which had subsided after a few minutes. A new catheter had been inserted. -3/29/26 at 2:31 a.m., Resident E pulled her catheter out. She had no bleeding or complaints of pain. The catheter was re-inserted which the resident tolerated well. -4/2/26 at 7:00 p.m., the resident was observed on the floor next to her bed, incontinent of urine, with her foley catheter dislodged. -4/20/26 at 3:17 a.m., the resident had removed her foley catheter, which was observed on the floor beside her bed. She was agitated and would not allow staff to replace the catheter. -At 3:29 a.m., the nurse received a call back from the on-call hospice nurse who ordered the foley catheter be left out until hospice could make an in-person visit later in the morning.-At 12:06 p.m., Resident E had urinated during the day shift. -5/16/26 at 7:19 a.m., the evening nurse had reported, the resident had not urinated on evening shift nor had she urinated on night shift. There were no assessments related to urinary continence completed after removal of Resident E's catheter on 4/20/26. There were also no changes made to her care plan or physician's order for the catheter to be discontinued. There were no interventions or plan put in place to monitor resident's ability to urinate after the removal of the catheter or a plan to restore the resident's bladder function. Treatment Administration Records (TAR), dated April 2026 and May 2026, indicated nursing staff continued to document, per initials, that catheter care had been provided as ordered on 3/17/26, even though the catheter had been left out on 4/20/2026 and there was no documentation it had been (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reinserted. During an interview with the Interim Director of Nursing (DON), on 6/1/26 at 4:35 p.m., she indicated she was not aware of why the urinary catheter had been placed for Resident E prior to or had been continued after admission to the facility. When asked, she indicated a physician order to discontinue the catheter should have been obtained and nurses were expected to have assessed and monitored the resident after the removal of an indwelling catheter to ensure the resident was able to urinate. Facilitation of Elimination was retrieved from the National Library of Medicine at www.ncbi.nlm.nih.gov on 6/1/26 which indicated nursing interventions related to facilitating elimination included inserting urinary catheters and preventing complications.indwelling urinary catheters should be used only for appropriate indications.catheter associated urinary tract infection (CAUTI) is a common complication caused by indwelling urinary catheters.Signs and symptoms of CAUTI should be monitored and reported to the physician.It is the nurse's responsibility to assess for continued need for an indwelling catheter daily and advocate for removal when appropriate.After removal of an indwelling catheter, patients should be encouraged to increase fluid intake, monitor ability to urinate within 4-6 hours after catheter removed, and assessed for bladder tenderness, distension, or urinating small amounts frequently. A current facility policy, titled Urinary Continence and Incontinence Assessment and Management was provided by the Administrator on 6/1/26 at 5:02 P.M. The policy indicated the facility was to provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. Indwelling urinary catheters were to be used sparingly for appropriate indications only. If a resident/patient was admitted from the hospital with a newly placed indwelling catheter, the Attending Physician and staff were to evaluate the potential for removing it, depending on the current condition and the rationale for its original placement. The physician was to identify situations in which an indwelling catheter was indicated and document why other alternatives were not feasible. If an indwelling catheter was needed, staff were to monitor for and report complications such as UTI's. A policy/procedure specific to indwelling urinary catheters was requested but not provided during the survey. This Citation relates to Intake 3026032. 410 Indiana Administrative Code (IAC) 16.2-3.1-41(2)(a)