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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Pilgrim Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51598</p> <p>Based on interview and record review, the facility failed to allow residents to exercise their rights when choosing where to eat for 3 of 3 resident reviewed for resident rights. (Resident C, D and N)</p> <p>Findings include:</p> <p>1. During an interview on 11/22/2024 at 10:27 A.M., Resident C indicated she was not allowed to eat in her room and all meals were to be eaten in the dining room.</p> <p>A record review for Resident C was completed on 11/25/2024 at 8:27 A.M. Diagnosis included, but were not limited to: schizoaffective disorder (bi-polar type), depression, anxiety, extrapyramidal and movement disorder.</p> <p>The current diet order for Resident C indicated she was on a regular diet with thin consistency.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment. dated 11/01/2024, indicated Resident C was cognitively intact and only required set-up assistance for eating.</p> <p>During an interview, on 11/26/2024 at 1:35 P.M., Resident C indicated that if you were feeling bad or just did not want to eat in the dining room, staff would not bring a tray to your room. If you were hungry, you would have to go to the dining room. She indicated she was allowed to eat in her room once, but only because staff felt she was too sick to go to the dining room.</p> <p>During an interview on 11/26/24 at 03:28 P.M., RN #14 indicated that the North Hall residents were more independent and could go down to the dining room and they were not allowed to get their meals in their rooms. He indicated that was the way he understood the facility's policy. RN #14 indicated he had been instructed to encourage the residents to go down to the dining room for meals, otherwise the resident would not receive a meal.</p> <p>During an interview on 11/27/24 at 10:58 A.M. CNA #13 indicated residents could not eat in their rooms because they were able to get up and go to the dining room. CNA #13 indicated staff were to encourage residents to go to the dining room and if they still did not want to eat in the dining room, they were not to receive a meal.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. A record review for Resident N was completed on 11/25/2024 at 3:15 P.M. Diagnosis included, but were not limited to: vascular dementia without disturbances, depression, fibromyalgia, and anxiety.</p> <p>The current diet order for Resident C indicated she was on a regular diet with thin consistency.</p> <p>A Quarterly Minimum Data Set (MDS) Assessment, dated 11/08/2024, indicated Resident N was cognitively intact and required set-up assistance for eating.</p> <p>A current Care Plan, dated 7/28/2024, indicated the resident needed help with self-care related to: lack of motivation. Interventions included but were not limited to: -Eats meals in west dining room, had food in her room if she chose not to eat in the dining room. Independent with transfer, bed mobility, toileting, toileting hygiene, eating.</p> <p>During an interview, on 11/26/2024 at 2:50 P.M., Resident N indicated that North Hall were independent and if they did not go down to the dining room they were on their own for that meal. The resident indicated she kept food in the fridge in her room in case she did not feel like going down to the dining room because staff would not bring a tray to her room.</p> <p>3. During an interview on 11/26/24 2:40 P.M., Resident D indicated that if she was not feeling good, she would have to go to the dining room for meals. She also indicated there were a couple times she did not want to go down but had to go because staff would not bring any food to her room. She indicated she was allowed to eat in her room once, but only because staff felt she was too sick to go to the dining room.</p> <p>A record review for Resident D was completed on 11/27/2024 at 11:20 A.M. Diagnosis included, but were not limited to: depression, anxiety, CKD, unspecified dementia without disturbances.</p> <p>A current care plan dated 8/9/2024 indicated the resident needed little help with self care</p> <p>Interventions included but were not limited to: independent in eating, eats all meals in the west dining room.</p> <p>The current diet order for Resident D indicated she was on a regular diet with thin consistency.</p> <p>A Quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated Resident C was cognitively intact and only required set-up assistance for eating.</p> <p>During an interview on 11/27/24 at 1:22 PM., the Dietary Manager indicated she did not recall anyone on North Hall ever receiving a room tray and she did not know if residents were allowed to eat in their rooms. She indicated she would expect staff to have asked for a room tray if a resident stayed in their room for the meal.</p> <p>A current policy was provided on 11/27/2024 at 3:20 P.M. by the DON, titled, Quality of Life-Residents Self Determination and Participation. The policy included the following: Each resident is allowed to choose activities, schedules and health care that are consistent with his or her interests, values, assessments and plans of care, including: daily routine, such as sleeping and waking, eating .</p> <p>3.1-3(u)(1)</p> <p>(continued on next page)</p> | | |

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| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p>45120</p> <p>Based on record review and interview, the facility failed to provide quarterly statements for 2 of 2 residents reviewed for personal funds. (Residents 5 & E)</p> <p>Findings include:</p> <p>1. During an interview, on 11/22/2024 at 10:46 A.M., Resident 5 indicated she had not received quarterly statements for her personal funds account at the facility. She indicated if she needed to know her account's balance, the Business Office Manager (BOM) would verbally tell her the balance of the account.</p> <p>A record review for Resident 5 was completed on 11/25/2024 at 9:32 A.M. Diagnoses included, but were not limited to: dementia with psychotic disturbance, psychotic disorder with delusions, bipolar disorder, generalized anxiety disorder and depressive disorder.</p> <p>An Annual Minimum Data Set (MDS) assessment, dated 11/13/2024, indicated Resident 5 was cognitively intact.</p> <p>2. During an interview, on 11/21/2024 at 2:38 P.M., Resident E indicated he had only received one quarterly statement since his admission to the facility, on 7/28/2023.</p> <p>A record review for Resident E was completed on 11/25/2024 at 10:53 A.M. Diagnoses included, but were not limited to: heart failure, atrial fibrillation, and hypertensive heart with heart failure.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 11/6/2024, indicated Resident E was cognitively intact.</p> <p>During an interview, on 11/27/2024 at 12:59 P.M., the BOM indicated the residents received personal fund statements whenever they asked for a statement. She indicated she tried to give the residents a statement anytime they withdrew money. The statement included the beginning and ending balances of their account. She indicated there were no specific time frames for personal fund statements to be provided to the residents. The Business Office Manager was unable to provide any documentation the residents and/or their representatives had received quarterly resident fund account statements.</p> <p>A policy was provided on 11/27/2024 at 3:30 P.M. by the Director of Nursing. The policy titled, Accounting and Records, indicated, .2. The individual financial record will be available through quarterly statements and on request to the resident or his or her legal representative</p> <p>3.1-6(g)</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>38845</p> <p>Based on interview and record review, the facility failed to complete a self administration of medication assessment timely for 1 of 1 resident reviewed for self administration of medications. (Resident N)</p> <p>Finding includes:</p> <p>During an interview, on 11/26/2024 at 9:11 A.M., Resident N indicated the nurse left her medications in her room and she took her medications herself.</p> <p>During an interview, on 11/26/2024 at 9:13 A.M., QMA 16 indicted it was okay to leave Resident N's medications in her room because she was alert and oriented.</p> <p>A current Care Plan, initiated on 7/28/2024, indicated the resident had requested to administer his/her own medications. Interventions included: The nurse was to bring medications to her room, all medications may be left with resident to take without assistance except for narcotics.</p> <p>A current physician order, dated 8/18/2024, indicated the following: may leave medications at bedside every shift.</p> <p>A Self Administration of Medications Assessment, dated 5/28/2024, was provided by the Director of Nursing and indicated Resident N was able to self administer medications.</p> <p>The Director of Nursing indicated the last Self Administration of Medication Assessment was completed on 5/2024 and she was unable to provide more recent assessments for August or November.</p> <p>On 11/27/2024 at 12:41 P.M.,the Director of Nursing provided the policy titled, Self Administration of Medications, dated 5/20/2020, and indicated the policy was the one currently use by the facility. The policy indicated . 3. The interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis</p> <p>3.1-50(a)(1)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>45120</p> <p>Based on record review and interview, the facility failed to ensure a comprehensive plan of care was created for a resident with medical conditions of antiplatelet use, seizure disorder, gastroesophageal reflux disease (GERD) and glaucoma (Resident 39), a resident with splints to the wrist and fifth finger (Resident 22), and a resident with a pacemaker (Resident 29) for 3 of 19 residents reviewed for comprehensive care plans.</p> <p>Findings include:</p> <p>1. A record review for Resident 39 was completed on 11/25/2024 at 10:19 A.M. Diagnoses included, but were not limited to: hemiplegia, seizure disorder, GERD and glaucoma.</p> <p>A Quarterly Minimum Data Set (MDS) assessment indicated Resident 39 received an antiplatelet medication, had range of motion limitations to one upper and lower extremity and had moderate impairment of her vision.</p> <p>A Physician's Order, dated 8/20/3034, indicated Resident 39 received clopidogrel (antiplatelet medication) 75 milligrams daily related to hemiplegia, levetiracetam (antiseizure medication) 750 milligrams twice daily for seizures, carbamazepine (antiseizure medication) 200 milligrams twice daily for seizures, pantoprazole (proton pump inhibitor) 40 milligrams daily for GERD and dorzolamide-timolol (topical beta blocker) 2 percent one drop in both eyes twice daily for glaucoma.</p> <p>A review of Resident 39's comprehensive plan of care indicated Resident 39 did not have a plan of care for antiplatelet use, seizure disorder, GERD or glaucoma.</p> <p>During an interview, on 11/27/2024 at 1:15 P.M., the Director of Nursing indicated Resident 39 should have had a plan of care for antiplatelet use, seizure disorder, GERD and glaucoma.</p> <p>49229</p> <p>2. During an observation, on 11/21/2024 at 11:39 A.M., Resident 22 had her right pinky finger splinted with two flat, wooden sticks and secured with paper tape.</p> <p>During an observation, on 11/25/2024 at 12:26 P.M., Resident 22 wore a firm black, cloth splint on her right wrist and 5th digit.</p> <p>The medical record for Resident 22 was reviewed on 11/25/2024 at 8:41 A.M. Diagnoses included, but were not limited to: resistant hypertension, Alzheimer's disease, depression, diabetes mellitus, chronic obstructive pulmonary disease, heart failure, dementia, chronic fatigue syndrome and unsteadiness on feet.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 10/24/2024, indicated the resident was mildly cognitively impaired with no hallucinations or delusions. The MDS indicated the resident had no falls since the last assessment.</p> <p>(continued on next page)</p> | | |

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| <p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The current Physician's Orders included an order for an x-ray of the right wrist one time only for pain, dated and completed on 11/16/2024.</p> <p>An Occupational Therapy Evaluation, dated 11/21/2024, indicated Resident 22's recommendations included wearing a splint full-time with skin checks and hygiene after every meal and prior to bedtime.</p> <p>There was no care plan for Resident 22 regarding the use of splints.</p> <p>During an interview, on 11/26/2024 at 11:31 A.M., the Director of Nursing (DON) was unable to provide Resident 22's care plan for the splint use and verbalized there was not a care plan for the splint.</p> <p>38845</p> <p>3. The record for Resident 29 was reviewed on 11/27/2024 at 9:47 A.M. Diagnoses included, but were not limited to: obesity, chronic ischemic heart disease, pacemaker, spinal stenosis, chronic pain syndrome, and hypertension.</p> <p>An Admission Nursing Assessment, dated 10/31/2024, indicated the resident had a pacemaker. Under the comments section was documented: resident stated that she hasn't had her pacemaker checked since last year.</p> <p>The History and Physical form from the hospital dated, 10/31/2024, indicated under surgical history was documented as Pacemaker/Defibrillator 2020.</p> <p>The clinical record lacked a care plan for the use and care of the pacemaker.</p> <p>During an interview, on 11/27/2024 at 10:39 A.M., the Director of Nursing indicated there should have been a care plan for the pacemaker on the chart.</p> <p>On 11/27/2024 at 12:42 P.M., the Director of Nursing provided the policy titled, Care Plans, Comprehensive Person -Centered, dated 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated . 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develop and implements a comprehensive, person-centered care plan for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change</p> <p>3.1-35(a)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>45120</p> <p>Based on record review and interview, the facility failed to follow bowel movement protocols. This resulted in the resident obtaining an ileus (a painful obstruction of the ileum or other part of the intestine) for 1 of 3 residents reviewed for quality of care. (Resident K)</p> <p>Finding includes:</p> <p>A record review for Resident K was completed on 11/26/2024 at 10:16 A.M. Diagnoses included, but were not limited to: Alzheimer's disease and constipation.</p> <p>The Quarterly Minimum Data Set (MDS) assessment, completed on 6/25/24 indicated the resident was severely cognitively impaired, was incontinent of her bladder and continent of her bowels and required some partial staff assistance for personal hygiene needs.</p> <p>A current Care Plan, initiated on 7/30/2024, indicated Resident K had the potential for constipation related to decreased mobility. The goal was for the resident to have a soft formed bowel movement at least every 3 days. Interventions included, but were not limited to: administer medications as ordered, check how often bowel movements occur, encourage fluid intake, give routine medications as ordered, check for bowel sounds, abdominal pain or swelling as needed, three times per week and report complaints of bowel problems to the nurse.</p> <p>The August 2024 physician's order recapitulation did not include orders for any as needed medications to soften stools and/or promote regular bowel movements (laxatives).</p> <p>The August 2024 bowel record forms indicated Resident K had a large bowel movement on 8/16/2024 during the day shift. There was no documentation of any bowel movements for Resident K in the nurse's notes or in the daily nursing bowel record form on 8/17/2024 and 8/18/2024. There was no documentation in assessments or nursing progress notes that the resident was assessed due to having gone two days without a bowel movement per the facility bowel protocol policy.</p> <p>On 8/19/2024 the bowel record form indicated Resident K had a small bowel movement on the evening shift. There was no documentation of any bowel movements for Resident K in the nurse's notes or in the daily nursing bowel record form from 8/20/2024 through 8/25/2024. There was no documentation in assessments or nursing progress notes that the resident was assessed due to having gone 5 days without a bowel movement. The physician was not notified and there were no PRN (as needed) medications to promote bowel movements administered to Resident K per the facility's bowel protocol policy.</p> <p>On 8/26/2024 during the night shift, the resident was documented as having a small bowel movement. A Physician's Progress Note, on 8/26/2024 at 10:17 P.M., indicated the family was concerned about Resident K due to abdominal swelling. An order was obtained for a 2-view abdominal x-ray. Physician Orders for Resident K, dated 8/26/2024, indicated the following medications were ordered: bisacodyl (medication to treat constipation) 5 milligrams daily, bisacodyl 10 milligram suppository (medication to treat constipation) as needed, docusate sodium (stool softener) 100 milligrams twice daily for 3 days and Milk of Magnesia (laxative) 30 milliliters as needed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>A Nursing Progress Note, on 8/27/2024 at 12:29 P.M., indicated the results of the abdominal x-ray were received. The results indicated, .5.4 centimeter dilated air-filled large bowel loops within the abdomen and pelvis in keeping with ileus in the appropriate clinical setting A Nursing Progress Note, on 8/28/2024 at 12:35 A.M., indicated Resident K had no regular bowel movements after 8/16/2024. An order was received from the nurse practitioner for a bisacodyl suppository if no bowel movement after 4 hours.</p> <p>A Nursing Progress Note, on 8/28/2024 at 2:39 P.M., indicated new orders were obtained from the physician including: absolutely no enema, 2 doses of MiraLAX 2-3 hours apart then continue as needed for constipation, Senna Plus 50 milligrams/8.6 milligrams 2 tablets a day for 7 days then 2 tablets at night, and if no bowel movement give another suppository tonight at bedtime.</p> <p>The August 2024 Medication Administration Record indicated although biscodyl 5 milligram tab was ordered on 8/26/2024 to be administered twice daily until 8/29/2024, the resident did not receive any tablets until 8/29/24. Resident K was also not administered the bisacodyl suppository, docusate sodium or Milk of Magnesia from 8/26/2024 through 8/29/2024. The August bowel record indicated the resident had a small bowel movement on the evening shift of 8/26/2024 and 8/28/2024. There was no bowel movement documented on 8/27/2024 for Resident K.</p> <p>A Nursing Progress Note, on 8/29/2024 at 5:01 P.M., indicated Resident K has not had a bowel movement since the last orders were received and administered. A new physician's order was received to give another dose of MiraLAX if no bowel movement happened and to give MiraLAX 17 grams three times a day for 4 days. There was no bowel movement documented for Resident K on 8/29/2024 and 8/30/2024.</p> <p>A Nursing Progress Note, on 8/30/2024 at 11:23 A.M., indicated a physician's order was received to repeat an abdominal x-ray on 8/30/2024. A medium bowel movement on the evening shift was documented for Resident K on 8/31/2024.</p> <p>A Nursing Progress Note, on 9/2/2024 at 4:26 P.M., indicated Resident K's bowel sounds were present in all quadrants of the resident's abdomen. The resident's abdomen was firm and distended with discomfort noted on gentle palpation. An extra-large bowel movement was also noted.</p> <p>A Nursing Progress Note, on 9/2/2024 at 6:48 P.M., indicated the following results of the abdominal x-ray. dilated large bowel loops noted in the central abdomen, maximum transverse diameter of 5.5 centimeters . No significant interval change A new order was received to repeat the abdominal x-ray on 9/4/2024 and to continue with the current orders.</p> <p>A Nursing Progress Note, on 9/5/2024 at 1:04 P.M., indicated bowel sounds were present with slight abdominal distention noted. The resident's last bowel movement charted, on 9/5/2024, was a medium size. The physician reviewed the abdominal x-ray and gave orders to continue the currently ordered plan of care.</p> <p>During an interview, on 11/27/2024 at 8:53 A.M., CNA 8 indicated Resident K was a one person assist and was incontinent of bowels at times.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview, on 11/27/2024 at 12:53 P.M., LPN 20 indicated the facility's bowel movement regimen included the following: two days of no bowel movement to give prune juice, three days of no bowel movement to give oral laxative, four day of no bowel movement to give suppository or enema and 5 days of no bowel movement or result to call the physician.</p> <p>A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, Bowel Protocol, indicated, .To provide effective interventions for signs and symptoms of constipation that are consistent with current standards of practice .1. Nursing staff document the resident's bowel movements each shift .2. The evening shift nurses assesses the bowel movement data daily and responds according to the protocol and/or physician orders. 3. If no bowel movement is recorded for two days: a. Assess for signs and symptoms of constipation. b. If the resident is alert and oriented, ask about any unrecorded bowel movements and assess for constipation. c. If acute abdominal symptoms are present, contact the physician immediately. 4. If no bowel movement is recorded for 3 days: a. In the absence of acute abdominal symptoms, administer a PRN [as needed] laxative or enema as ordered by the physician. b. If no PRN is ordered, contact the physician and relay the resident's status and request a laxative and/or enema. c. If acute abdominal symptoms are present, contact the physician immediately. 5. After 4 days with no bowel movement or inadequate response to previous interventions, contact the physician</p> <p>This citation is related to complaint investigation IN00447285.</p> <p>3.1-37(a)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45120</p> <p>Based on record review and interview, the facility failed to prevent a burn for 1 of 1 resident reviewed for accident hazards. (Resident M)</p> <p>Finding includes:</p> <p>A review of a facility reported incident was reviewed on 11/25/2024 at 11:12 A.M. The facility reported, on 11/20/2024 at 9:50 P.M., during skin rounds a nurse discovered an area on the bilateral inner legs of Resident M to be blistered. It was believed Resident M spilt soup on her lap. An investigation was initiated. The follow-up investigation indicated after interviewing staff, there were no witnesses to determine whether a hot liquid had spilt on Resident M's lap. Resident M required staff assistance to eat. The physician had examined the wounds and determined the wounds to be nonthermal. The resident's care plan was reviewed and updated.</p> <p>A Witness Statement from CNA 16, dated 11/19/2024, indicated, .Around supper time at 6:10 P.M., she has her dinner in front of her. I got up to give [another resident name] his dinner. Start [sic] to feed [Resident M] when I seen she was missing her soup. I said to my co-worker, ok, you got no soup -n- [Resident M] said yes I did. I said were [sic, where] is it. She on my lap. I said omg [oh my god]. It was hot. So [I] put a cold wash cloth on her but I seen it was red. So I got her to bed. Check her again still red. N- on-11/20/2024 went to get her cleaned up I saw it has got red again. But yesterday I did tell the nurse, because it te [tell] my co/work [coworker] it was red. So tonight it still red to [so] told the nurse to check again.</p> <p>A Witness Statement written by LPN 17, dated 11/20/2024, indicated, on 11/19/2024, CNA 16 let her know Resident M had some redness on her leg. LPN 17 indicated observation of Resident M's legs indicated they were light pink in color. LPN 17 inquired to CNA 16 what happened and CNA 16 indicated she thought Resident M spilt soup on herself, but mentioned it happening a different day. LPN 17 indicated during Resident M's skin assessment; Resident M had blisters.</p> <p>A Witness Statement written by RN 18, dated 11/20/2024, indicated LPN 17 asked for a second opinion on Resident M's skin. RN 18 indicated upon observation there were small blisters between her thighs. LPN 17 indicated CNA 16 reported soup had fallen on Resident M's lap. CNA 16 had indicated she believed the incident happened on Sunday (11/17/2024) when she was working with CNA 19.</p> <p>A Witness Statement written by CNA 19, dated 11/20/2024, indicated Resident M did not have any soup. As CNA 19 had observed the situation she noticed Resident M had spilt her soup onto her lap. CNA 16 and CNA 19 took Resident M's lap blanket off and witnessed a red area on her left inner thigh. CNA 19 indicated LPN 17 observed the area and the incident occurred on 11/19/2024.</p> <p>A record review for Resident M was completed on 11/26/2024 at 2:18 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, contracture of right hand and physical debility.</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A Quarterly Minimum Data Set (MDS) assessment, dated 9/20/2024, indicated Resident M had severe cognitive deficiency, no impairment of the extremities, and required maximal/substantial assistance for eating.</p> <p>A Nursing Progress Note, on 11/20/2024 at 9:49 P.M., indicated during a skin assessment Resident M was noted to have blisters on her right and left thigh.</p> <p>A Hot Liquid Safety Evaluation, on 11/21/2024 at 10:05 A.M., for Resident M was completed. The evaluation indicated Resident M had cognitive impairment or drowsiness that impacted the resident's perception and awareness to hot liquids and safety measures including, but not limited to: altered comprehension and/or memory impairment, altered muscle strength of the arms, hands, and fingers, tremors or abnormal muscle movements of the arms, altered range of motion or contractures of the joints(s) to the dominant side of the wrist, fingers and hand, episodes of behavior which could cause injury if occurred while Resident M was handling hot liquids, and a history of spilling liquids. The interventions included a cup with lid or other adaptive cup, staff assistance and to drink hot liquids at the dining table.</p> <p>A Nursing Progress Note, on 11/21/2024 at 12:18 P.M., indicated Resident M was seen by the nurse practitioner and orders were received for Silvadene cream twice daily with nonadherent dressing.</p> <p>A Physician History and Physical, dated 11/21/2024, indicated Resident M had the diagnoses of non-thermal blister and contact with hot food.</p> <p>A Weekly Non-Pressure Other Injury Evaluation, on 11/21/2024 at 1:23 P.M., indicated an initial facility acquired right thigh toward the back blister measuring 7 centimeters by 1 centimeter.</p> <p>A Weekly Non-Pressure Other Injury Evaluation, on 11/21/2024 at 1:24 P.M., indicated an initial facility acquired left lower leg blister from a burn measuring 4 centimeters by 2 centimeters.</p> <p>A Care Plan for prevention for burns was not developed.</p> <p>During an interview, on 11/27/2024 at 12:55 P.M., LPN 20 indicated a Hot Liquid Safety Evaluation would be completed on admission and quarterly to determine risk of burns.</p> <p>During an interview, on 11/27/2024 at 3:32 P.M., the Regional Director of Nursing Services indicated that the blisters were determined nonthermal from the physician, so further action was not needed.</p> <p>A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, Safety of Hot Liquids, indicated, .Residents will be evaluated for safety concerns and potential for injury from hot liquids. Appropriate precautions will be implemented to maximize choice of beverage while minimizing the potential for injury .1. The potential for burns from hot liquids is considered an ongoing concern among residents with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal conditions. 2. Residents with these or other conditions may suffer from accidental burns and related complications stemming from thinner, more fragile skin that may burn more quickly and severely and take longer to heal. 3. Residents who prefer hot beverages with meals [i.e., coffee, tea, soup, etc.] will not be restricted from these options. Instead, staff will conduct regular Hot Liquid Safety Evaluation as indicated, and document the risk factor for scalding and burns in the care plan</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>This citation is related to complaint investigation IN00447285.</p> <p>3.1-45(a)(2)</p> |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>45120</p> <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, record review and interview the facility failed to ensure nebulizer equipment and nasal cannula tubing were stored and dated properly (Resident 16), failed to ensure nasal cannula tubing was changed per physician orders and oxygen concentrator filters were cleaned as needed (Resident 16) and failed to provide oxygen hydration equipment (Resident F) for 3 of 3 residents reviewed for respiratory therapy.</p> <p>Findings include:</p> <p>1. During an observation, on 11/21/2024 10:13 A.M., the handheld aerosol nebulizer for Resident 53 was lying on the bedside table. There was no date on the oxygen tubing or on the nasal cannula.</p> <p>During an interview, on 11/21/2024 at 11:25 A.M., Resident 53 indicated the staff did not normally store the handheld aerosol nebulizer in bags.</p> <p>During an interview, on 11/21/2024 at 2:54 P.M., Resident 53 indicated the staff had placed a dated paper tape label on her nasal cannula about an hour ago. She indicated the nasal cannula was not changed. A date of 11/21/2024 was observed written on paper tape attached to the nasal cannula.</p> <p>During an observation, on 11/22/2024 at 9:57 A.M., the handheld aerosol nebulizer was observed lying on the over-the-bed table.</p> <p>During an observation, on 11/27/2024 at 8:48 A.M., the handheld aerosol nebulizer was observed attached to the nebulizer machine without a covering.</p> <p>A record review for Resident 53 was completed on 11/25/2024 at 12:16 P.M. Diagnoses included, but were not limited to: pneumonia, acute and chronic respiratory failure, obstructive sleep apnea and chronic obstructive pulmonary disease (COPD).</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 10/1/2024, indicated Resident 53 was cognitively intact and received oxygen therapy.</p> <p>A Physician's Order, dated 8/18/2024, included the following: -oxygen at 2 liters per minute via nasal cannula for shortness of breath and change oxygen tubing every night shift on Sundays.</p> <p>A Physician's Order, dated 9/8/2024, indicated Albuterol Sulfate nebulization solution 2.5 milligrams per 3 milliliters inhale 3 milligrams via nebulizer two times a day for COPD.</p> <p>There was not an order to change or store the handheld aerosol nebulizer equipment.</p> <p>A current Care Plan, initiated on 7/27/2024, indicated Resident 53 had the potential for ineffective breathing related to chronic lung disease, pneumonia, acute and chronic respiratory failure with hypoxia, obstructive sleep apnea and COPD. The interventions included, but were not limited to, administer oxygen as ordered, change oxygen tubing weekly and to give breathing treatments as ordered.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview, on 11/27/2024 at 8:49 A.M., LPN 2 indicated nebulizer equipment should be stored in a bag with the resident's name on the bag and the oxygen and nebulizer tubing should be dated.</p> <p>38845</p> <p>2. The record for Resident 16 was reviewed on 11/25/2024 at 9:42 A.M. Diagnoses include, but were not limited to: chronic diastolic congestive heart failure, pacemaker, chronic obstructive pulmonary disease, and chronic kidney disease stage 3.</p> <p>During an observation, on 11/21/2024 at 3:25 P.M., Resident 16's oxygen tubing was dated 11/12/2024, and the filter to the back of the concentrator was covered with dust.</p> <p>During an observation, on 11/22/2024 at 9:47 A.M., the filter to the back of the oxygen concentrator was covered with dust.</p> <p>During an observation. on 11/26/2024 at 9:48 A.M., the filter to the back of the oxygen concentrator was covered with dust.</p> <p>Current Physician Orders included: Change O2 tubing and/or updraft tubing, including oxy ear to tubing every night shift on Thursday for Equipment change date and initial tubing.</p> <p>A current Care Plan, initiated on 10/17/2024, indicated the resident has Oxygen Therapy related to chronic obstructive pulmonary disease (COPD). Interventions included, but were not limited to: Give medications as ordered by physician. Monitor/document side effects and effectiveness. The resident has O2 at 2L (liters) via nasal prongs continuously to keep saturations above or equal to 90% as ordered.</p> <p>During an interview, on 11/26/2024 at 10:05 A.M., LPN 5 indicated the filter should have been cleaned and was not.</p> <p>3. The record for Resident F was reviewed on 11/25/2024 at 12:08 P.M. Diagnoses included, but were not limited to: retention of urine, neuromuscular dysfunction of the bladder, dementia, and Legionnaires disease.</p> <p>During an observation, on 11/22/2024 at 9:30 A.M., Resident F's oxygen tubing was applied straight into the machine with no humidification water bottle.</p> <p>During an observation, on 11/25/2024 at 9:12 A.M., Resident F's oxygen tubing was applied straight into the machine with no humidification water bottle.</p> <p>During an observation, on 11/26/2024 at 9:45 A.M., Resident F's oxygen tubing was applied straight into the machine with no humidification water bottle.</p> <p>A current Physician Order, initiated on 10/24/2024, indicated the following: Change oxygen tubing, and humidification bottle, clean oxygen filter, inspect easy foam wraps (replace if soiled or missing) every night shift every Thursday and as needed.</p> <p>(continued on next page)</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview, on 11/26/2024 at 10:03 A.M., LPN 5 indicated there should be a humidification bottle on the concentrator.</p> <p>On 11/27/2024 at 12:40 P.M. the Director of Nursing provided the policy titled, Oxygen Administration, dated 2010, and indicated the policy was the one currently used by the facility. The policy indicated . Equipment and Supplies: The following equipment and supplies will be necessary when performing this procedure . 3. Humidifier bottle . 12. Check the mask, tank, humidifying jar, ect., to be sure they are in good working order and area securely fastened. Be sure there is water in the humidifying jar and the the water level is high enough that the water bubbles as oxygen flows through</p> <p>3.1-47(a)(6)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45120</p> <p>Based on observation, record review and interview, the facility failed to ensure physician ordered medications were given and available for 1 of 9 residents whose medications were reviewed. In addition, the facility failed to ensure narcotics were counted and documented every shift for 1 of 4 narcotic count logbooks reviewed. (Residents K and North narcotic count sheets)</p> <p>Findings include:</p> <p>1. A record review for Resident K was completed on 11/26/2024 at 10:16 A.M. Diagnoses included, but were not limited to: Alzheimer's disease and constipation.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, dated 9/13/2024, indicated Resident K had significant cognitive impairment and was frequently incontinent of bowel.</p> <p>Physician Orders for Resident K, dated 8/26/2024, indicated the following medications: bisacodyl 5 milligrams daily, bisacodyl 10 milligram suppository as needed, docusate sodium 100 milligrams twice daily for 3 days and Milk of Magnesia 30 milliliters as needed. (medications to soften stools and/or promote regular bowel movements)</p> <p>The August 2024 Medication Administration Record indicated although bisacodyl 5 milligram tab was ordered on 8/26/2024, the resident did not receive any tablets until 8/29/24.</p> <p>There was no documentation in Nursing Progress notes or the facility's bowel tracking system to indicate Resident K had had regular bowel movements from 8/26/2024 through 8/29/2024.</p> <p>The August 2024 Medication Administration Record indicated although docusate sodium 100 milligrams capsule twice daily was ordered on 8/26/2024 to be given through 8/29/2024, the resident did not received any capsules.</p> <p>The August 2024 Medication Administration Record indicated although milk of magnesia 30 milliliters as needed was ordered on 8/26/2024, the resident had not received any doses.</p> <p>The August 2024 Medication Administration Record indicated although bisacodyl 10 milligram suppository as needed was ordered on 8/26/2024, the resident had not received any doses.</p> <p>38845</p> <p>2. A Medication Storage observation of the 400 hall medication cart was completed, on 11/25/2024 at 11:03 A.M., with LPN 2.</p> <p>The the narcotic log book lacked 24 signatures to show a narcotic count was completed.</p> <p>During an interview, on 8/9/2024 at 11:04 A.M., LPN 2 indicated the narcotic log sheets should have been signed every shift.</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 11/27/2024 at 12:41 P.M., the Director of Nursing provided the policy titled, Ordering and Receiving Medications, dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated .Medications and related products are received from the pharmacy in a timely manner. The facility maintains accurate records of medications ordered and received . b. If not automatically refilled by the pharmacy, refills are ordered as follows: i. Reorder medication when a four day supply remains, in advance of need, to assure an adequate supply is on hand. When reordering medication that requires special processing, please contact the pharmacy for special processing</p> <p>On 11/27/2024 at 12:45 P.M., the Director of Nursing provided the policy titled, Controlled Medication Storage, dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated . 1. Regulations required that the facility have a system to account for the receipt, usage, disposition, and reconciliation of all controlled medication(s). The system includes but is not limited to: .7. At each shift change, a physical inventory of all controlled medication(s), including the emergency supply, is conducted by two (2) licensed nurses and is documented on the controlled medication accountability record per facility procedure</p> <p>This citation relates to Complaint IN00442061.</p> <p>3.1-25(a)</p> <p>3.1-25(e)(2)</p> <p>3.1-25(e)(3)</p> <p>3.1-25(g)(3)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38845</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were stored appropriately and medication carts were free of loose pills for 2 of 2 medication carts observed. (400 hall medication cart and 100 hall medication cart)</p> <p>Findings include:</p> <p>1. During a medication storage observation, on [DATE] at 11:03 A.M., with LPN 2 on the 400 hall med cart, the following was observed: 6 loose pills in 3 of the 4 main drawers.</p> <p>During an interview, on [DATE] at 11:09 A.M., LPN 2 indicated the loose pills should not be in the medication cart.</p> <p>2. During a medication storage observation, on [DATE] at 11:16 A.M., with R.N. 15 on the 100 hall medication cart, the following was observed:</p> <ul style="list-style-type: none"> - a box of glucose test strips that had expired on [DATE]. - 3 loose pills in 2 drawers. - a opened container of Miralax (laxative) with no opened date. <p>During an interview, on [DATE] at 11:18 A.M., R.N. 15 indicated the loose pills should not be in the medication cart and the laxative should have a date opened in it.</p> <p>On [DATE] at 12:45 P.M., the Director of Nursing provided the policy titled, Medication Cart Disinfecting , undated and indicated the policy was the one currently used by the facility. The policy indicated .It is the policy of this facility that the medication cart will be maintained in a clean and orderly manner at all times</p> <p>3XXX,d+[DATE](j)</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45120</p> <p>Based on observation, record review and interview, the facility failed to ensure food was stored and prepared in a sanitary manner for 1 of 1 kitchens observed. This deficient practice had the potential to affect 71 of 73 residents who consumed food from the kitchen.</p> <p>Findings include:</p> <p>During initial kitchen observations, on 11/21/2024 from 9:30 A.M. through 9:48 A.M. with the Dietary Manager (DM), the following was observed:</p> <ul style="list-style-type: none"> - Opened cream base soup without an open date and stored unsealed. - Opened old fashioned biscuit gravy mix without an open date and stored unsealed. - Opened bag of coconut stored unsealed. - Opened pasta with no open date. - Opened chopped garlic sitting on a shelf with directions of to be refrigerate. - Spices of garlic herb seasoning, granulated garlic, granulated onion, parsley flakes and onion powder with no documented open date. - Mini freezer with heavy ice buildup. <p>During an interview, on 11/21/2024 at 9:49 A.M., the Dietary Manager indicated the opened bags of food in the dry storage should have been sealed and/or in a baggie and have an open date documented on them, the minced garlic should have been refrigerated and the spices should have open dates on the containers.</p> <p>During an observation, on 11/26/2024 at 10:30 A.M., the cream-based soup mix was still opened and not sealed. The mini freezer had heavy ice buildup.</p> <p>During an observation, on 11/26/2024 at 10:47 A.M., the sanitation bucket at the prep counter and at the dishwashing machine was tested for proper concentration. The test strip indicated a concentration of zero sanitation chemicals.</p> <p>During an interview, on 11/26/2024 at 10:49 A.M., the Dietary Manager indicated the concentration on the strip should have been between 200-400.</p> <p>(continued on next page)</p> | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 11/27/2024 |
| NAME OF PROVIDER OR SUPPLIER Pilgrim Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 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. | | | |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview, on 11/26/2024 at 2:12 P.M., the Dietary Manager indicated after changing the sanitation buckets, the buckets were tested again for concentration. The test strip indicated zero concentration. She indicated she had the maintenance department look at the automated sanitation disbursement system and the sanitation solution was not flowing through the tubing. It was unclear how long the chemical had not been mixing properly.</p> <p>During an interview, on 11/27/2024 10:35 A.M., the Dietary Manager indicated the mini freezer was not on a defrosting schedule, but the mini freezer was usually unplugged about every month and set outside to defrost.</p> <p>A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, Dietary Stock Procedure, indicated, .To be sure all stock is properly put away as soon as possible after delivery .4. Bulk items must be properly dated, with date received, expiration date, open date and new expiration date if needed .5. All food needs to have open date on them once opened & expiration date, if it changes</p> <p>A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, Freezer Cleaning, indicated, .Freezers will be defrosted as needed [when frost is 1/2 inch thick, the freezer should be defrosted], or per the manufacturer's instructions</p> <p>A policy was provided, on 11/27/2024 at 3:30 P.M., by the Director of Nursing. The policy titled, Cleaning cloths, Pads, Mops & Buckets, indicated, .Cleaning cloths should be kept in a container of clean sanitizing solution between use .Periodically test the sanitizing solution to assure that it maintains the correct concentration</p> <p>3.1-21(h)(2)</p> <p>3.1-21(h)(3)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Pilgrim Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 222 Parkview St Plymouth, IN 46563 | |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>49229</p> <p>Based on observation, record review and interview, the facility failed to ensure enhanced barrier precautions were in place for 1 of 1 residents observed during wound care. (Resident 60) and failed to store catheter tubing and drainage bags appropriately for 1 of 2 residents reviewed for catheters (Resident F).</p> <p>Findings include:</p> <p>1. The medical record for Resident 60 was reviewed on 11/25/2024 at 9:04 A.M. Diagnoses included, but were not limited to: rhabdomyolysis, paroxysmal atrial fibrillation, depression, anxiety, neuromuscular dysfunction of bladder, pressure ulcer of left buttock, dementia and diabetes mellitus.</p> <p>A Quarterly Minimum Data Set (MDS) assessment, dated 8/14/2024, indicated Resident 60 was severely cognitively impaired. The MDS indicated Resident 60 was dependent for eating, oral hygiene, toileting, showering/bathing, upper and lower body dressing, footwear and personal hygiene. Resident had an indwelling urinary catheter and was always incontinent of bowel. Resident 60 had one pressure ulcer that was present upon admission.</p> <p>A Physician's Order for Resident 60, dated 8/26/2024, indicated to maintain enhanced barrier precautions every shift for precautions.</p> <p>A current Care Plan, reviewed on 11/13/2024, indicated Resident 60 had an unstageable pressure ulcer to the coccyx. Interventions included but were not limited to: apply treatments as ordered.</p> <p>During an observation, on 11/25/2024 at 9:27 A.M., an Enhanced Barrier Precaution instruction sign was present and visible next to Resident 60's television on the wall.</p> <p>During an observation of care, on 11/25/2024 at 2:02 P.M., Employee 10, Employee 12 and Employee 4 gathered in Resident 60's room and performed hand hygiene. Employee 10 placed a barrier on the bedside table and placed wound care supplies on top of barrier. Employee 10, 12, and 4 all wore clean gloves but none of the employees wore gowns or face masks. Both Employee 12 and 4 handled Resident 60's body while Employee 10 performed the dressing change.</p> <p>During an interview, on 11/27/2024 at 10:56 A.M., Employee 11 indicated the term Enhanced Barrier Precautions (EBP) meant staff were required to wear gowns, gloves, and sometimes a mask, depending on the task performed in the resident room. Employee 11 indicated EBP was indicated for staff when a resident required urinary catheter care and/or wound care.</p> <p>During an interview, on 11/27/2024 at 11:05 A.M., Employee 3 indicated Enhanced Barrier Precautions meant staff were required to wear a gown and gloves when the staff gave residents Foley care and wound care.</p> <p>38845</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Pilgrim Manor | | STREET ADDRESS, CITY, STATE, ZIP CODE 222 Parkview St Plymouth, IN 46563 | |
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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>2. The record for Resident F was reviewed on 11/25/2024 at 12:08 P.M. Diagnoses included, but were not limited to: retention of urine, neuromuscular dysfunction of the bladder, dementia, and Legionnaires disease.</p> <p>Current Physician Orders for Resident F included the following: 16 French Foley catheter with 10 cc balloon with drainage bag to gravity. May change as needed for leakage, dislodgement or occlusion.</p> <p>A current Care Plan, dated 8/12/2024, indicated the resident had the potential for a urinary tract infection related to indwelling catheter due to urine retention manifested by fever, increase in confusion. Interventions included but were not limited to: Change and maintain 16 FR Foley catheter with 10 cc in balloon, with drainage bag to gravity as ordered. Empty catheter every shift and record output. Keep catheter drainage bag inside an outer bag for covering-</p> <p>Keep tubing kink free. Watch for blocked or encrusted catheter, drainage tubing or bag and change as needed. Watch for complications of catheter use: urine leakage, pink or blood tinged urine, bladder pain or spasms.</p> <p>During an observation, on 11/25/2024 at 12:22 P.M., Resident F's urinary catheter drainage bag was resting on the floor. The urinary drainage bag had a hard plastic box attached to the outside with numbers of ml's (milliliter) documented on the plastic box. The box contained over 400 ml's of dark orange colored urine. The Foley urinary drainage tube was filled with urine and was not able to drain into the drainage bag.</p> <p>During an observation, on 11/26/2024 at 9:53 A.M., the urinary drainage tube was on the floor. The box on the outside of the drainage bag was filled with over 400 ml of dark urine. The drainage tube had urine in it and was unable to drain into the drainage bag.</p> <p>During an interview, on 11/26/24 at 10:12 A. M., LPN 5 indicated the drainage bag was the one the resident had when she was admitted from the hospital and we don't use those and indicated the urinary drainage tubing should not be on the floor.</p> <p>On 11/21/2024 at 2:30 P.M., the Administrator provided a policy titled, Enhanced Barrier Precautions, dated 4/12/2024 and indicated the policy was the one currently used by the facility. The policy indicated .Enhanced Barrier Precautions are to be implemented in addition to Standard Precautions .when facility identifies any resident with .chronic wounds .</p> <p>On 11/27/2024 at 12:41 P.M., the Director of Nursing provided the policy titled, Catheter Care, Urinary, dated 2014, and indicated the policy was the one currently used by the facility. The policy indicated . Infection Control: . b. Be sure the catheter tubing an drainage bag are kept off the floor. c. Empty the drainage bag regularly</p> <p>3.1-18(a)</p> | | |