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	02/13/2026

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

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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 0691 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on interview, observation and record review, the facility failed to assess, notify the family and provider and document the change in the medical record after a resident developed blood in her colostomy (an opening in the abdominal wall, connecting the colon to the outside of the body to divert waste and gas) bag for 1 of 1 residents reviewed for colostomy care. This deficient practice resulted in a delay of treatment for a gastrointestinal bleed (GI) and anemia (low hemoglobin) and unexpected hospitalization. (Resident J) Finding includes: During an interview on 2/9/2026 at 12:02 P.M., Resident J indicated a staff member had found blood and blood clots in her colostomy bag and that the employee had taken a picture of the blood to show the nurse. Resident J was not able to recall what staff member had taken the picture, but did recall it was around the end of second shift (2:00 - 1030 P.M.) on 2/8/2026. Resident J indicated she had not been updated with any information related to the blood in her colostomy bag. During an observation of Resident J's colostomy bag on 2/9/2026 at 12:05 P.M., the bag was empty and did not contain stool or any blood. Resident J indicated the colostomy had last been emptied the night before. During an interview on 2/10/2026 at 9:00 A.M., Resident J indicated she had not been updated on the plan of care related to the blood in colostomy and she was having increased abdominal pain that the facility was giving her pain medications to treat. Resident J's record review was completed on 2/12/2026 at 11:02 A.M. Diagnoses included, but were not limited to: thrombocytosis, colostomy, schizophrenia, major depressive disorder, generalized anxiety disorder and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/8/2026, indicated Resident J had clear speech, adequate hearing, had been able to make herself understood and understands others, had been on an antiplatelet and had a colostomy present. Resident J had the following current Physician's orders:-An order, dated 12/17/2025, indicating Resident J was to have colostomy care every shift.-An order, dated 12/3/2025, indicated Resident J was to receive one 81 milligram (mg) tablet of aspirin (anti-platelet). -An order, dated 2/9/2026, indicated Resident J was to receive two 325 mg tablets of hydrocodone-acetaminophen (opioid pain reliever).A review of Resident J's pain scale indicated the resident had needed to be administered two 325 mg tablets of hydrocodone-acetaminophen for abdominal pain on 2/9/2025 at 9:30 P.M. due to a pain level of 9 (pain scale of 0-10 with 0 being no pain and 10 being the worst pain), 2/10/2026 at 2:11 A.M. due to pain level of 4 and 2/10/2026 at 5:12 P.M. due to pain level of 9. Before 2/9/2026 at 9:30 P.M., Resident J had not been administered a pain reliever since 2/6/2026 at 12:58 P.M.A current care plan, initiated on 12/10/2025 indicated Resident J had a colostomy related to a bowel resection. Interventions, initiated on 12/10/2025, indicated the staff would change the colostomy bag after each bowel episode or when full and Resident J would be educated on alerting the nurse regarding when to change the bag. A current Care Plan, initiated on 11/14/2025 indicated Resident J was on antiplatelet therapy and was at risk for bleeding. An intervention, initiated on 11/14/2025 indicated staff would observe for, document and report signs and symptoms of anticoagulant complications. Anticoagulant complications included but were not limited to dark or bright red blood in stools. Resident J's record lacked the documentation to indicate the blood and the blood clots found during ostomy care on 2/9/2025 during second shift had been assessed by a nurse, documented in the resident's medical (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0691 Level of Harm - Actual harm Residents Affected - Few	record or that the medical provider or Resident J's family had been notified of the change in the resident's condition. A Nursing Note, dated 2/10/2026 at 5:20 P.M., indicated Resident J continued to complain of abdominal pain and rated the pain as a 9 out of 10. The resident was displaying nonverbal indicators of pain and the resident reported pain medications had been ineffective. Resident J had not had any gas or stool output in over 30 hours, although the resident had been eating a regular diet. The last time the resident had had any output, there had been a small amount of stool with a small amount of blood. Resident vitals were: blood pressure of 136/80, heart rate of 90, respirations elevated at 22, blood oxygen level was 97.A Nursing Note dated 2/10/2026 at 5:33 P.M. indicated the provider had been updated on Resident J's pain, lack of output in her colostomy, hypoactive bowel sounds and blood in her stool. The provider indicated the resident should be sent to local Emergency Department (ED) for evaluation. A review of Resident J's ED note dated 2/10/2026 at 6:26 P.M. indicated resident arrived at the ED with a hemoglobin of 6.5 (normal 12-15) and a hematocrit of 20.1 (normal 36-48) and required two units of packed red blood cells to be transfused (blood transfusion). Resident J was found to have an acute GI bleed that had caused anemia and would require being transferred to a larger hospital in a different city and county. During an interview on 2/13/2026 at 9:18 A.M., the Unit Manager indicated Employee 8 had provided colostomy care to Resident J and during the care had noticed blood and blood clots in the resident's colostomy, on 2/8/2026, towards the end of second shift. Employee 8 had taken a picture of the contents of the colostomy and had sent the image to the nurse,Employee 9, who had been assigned to the resident. Employee 9 did not notice the message until many hours later, after his shift and after he had left the facility. Employee 9 called the third shift nurse (Employee 10) who was assigned to Resident J and forwarded the picture of the contents of the colostomy to Employee 10. Employee 10 had passed the message off on report the next morning to the first shift nurse, Employee 11. None of the employees, Employee 8, 9, 10 or 11, had documented the blood and blood clots in Resident J's colostomy or entered any notes related to the blood in the colostomy bag. Employees 9, 10 and 11 had not notified a provider or the resident's POA that the resident had blood and blood clots in her colostomy bag. During an interview on 2/13/2025 at 2:05 P.M., CNA 12 indicated she had seen blood and blood clots in Resident J's colostomy bag and had reported it in a message to the nurse assigned to the resident. CNA 12 indicated she had not followed up with the nurse related to Resident J and had not known the nurse had not seen the message. On 2/12/2026 at 2:00 P.M., the Executive Director provided an undated policy titled, Change in Resident's Condition or Status, and indicated it was the policy currently used by the facility. The policy indicated, .Our facility promptly notifies the resident, hir or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's attending physician or physician on call when there has been a[an].i. specific instruction to notify the physician of changes in the resident's condition.On 2/13/2026 at 11:58 A.M., the DON provided an undated policy titled, Charting and Documentation and identified it as the policy currently used by the facility. The policy indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition . 2. The following information is to be documented in the resident medical record: d. changes in the resident's condition 3.1-47(a)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to prepare and serve food under sanitary conditions related to staff hygiene in the kitchen and food temperature of hall trays for 1 of 1 kitchen areas observed. This issue had the potential to affect 62 of 62 residents who resided in the facility and received food from this dietary area.Findings include:During an interview, on 2/11/2026 at 11:20 A.M., the Dietary Manager indicated food remained on the steam table until it was plated or put on the resident meal trays.During an observation, on 2/12/2026 at 11:59 A.M. of the last hall tray, it was removed from the portable food cart and the Dietary Manager obtained the following food temperatures:Ham & scalloped potatoes:110 degrees Fahrenheit,Carrots:111 degrees Fahrenheit,Chocolate milk: 46 degrees Fahrenheit,Fruit cocktail: 60 degrees Fahrenheit. During an interview immediately following the temperature assessments, the Dietary Manager indicated the food should have been hotter (sic) than the recorded temperatures and indicated the facility had recently ordered new plate warmers.2. During an observation, on 2/11/2026 at 12:00 P.M., two maintenance staff were standing in the facility kitchen without hairnets with the kitchen door open. One of the maintenance staff was wearing a knit cap and was kneeling on the floor, the other maintenance staff was holding the kitchen door open.During an interview, on 2/11/2026 at 12:05 P.M., the Dietary Manager indicated hair nets was a requirement for all staff entering the kitchen.On 2/11/2026 at 1:40 P.M., the Administrator provided a policy titled, Employee Sanitary Practices, dated 7/2023 and indicated the policy was the one currently used by the facility. The policy indicated .Hair nets or caps, covering all of the hair, must be worn at all times.The cap must be one that is designated for kitchen use only.On 2/13/2026 at 3:56 P.M., the Administrator provided a policy titled, Temperatures, dated 7/2025 and indicated the policy was the one currently used by the facility. The policy indicated .Foods sent to the units for distribution.will be transported and delivered to maintain temperatures at or below 41 degrees F for cold foods and at or above 135 degrees F for hot foods and hot beverages.3.1 - 21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow infection control practices related to hand hygiene procedures and wound care procedures for 1 of 1 resident reviewed for pressure ulcers. (Resident 34) In addition, the facility failed to track and complete infection surveillance during a COVID (Coronavirus) outbreak. Findings include: 1.During an interview, on 2/10/2026 at 11:26 A.M., a resident representative indicated Resident 34 had a pressure ulcer on her coccyx. During an observation, on 2/12/2026 at 12:25 P.M., Resident 34 was observed receiving wound care for the wound on her coccyx. Certified Nursing Assistant (CNA) 14 and the IP (Infection Prevention) nurse were already standing outside Resident 34's room. They had both donned gowns, masks and were wearing disposable gloves. An additional staff member, CNA 7 was observed to open the door with Resident's room door, then after she had entered Resident 34's room, CNA 7 closed the door, pulled two disposable gloves from a box stored behind the resident's door and applied the gloves to her hands without performing any hand hygiene. CNA 14, the IP Nurse and CNA 7 assisted Resident 34 to reposition to her right side and removed a slightly wet incontinence brief from the resident Resident 34 did not have any dressing over the open area on her coccyx which was approximately the size of a quarter. The IP nurse removed her gloves, applied hand sanitizer and put on clean gloves. Next, IP nurse opened a sterile 4 x 4 sized gauze squares package and moistened several gauze pads with wound cleanser from a spray bottle. She then proceeded to take one of the moistened gauze pads to wipe the coccyx wound from the direction of the southern edge nearest the tailbone towards the resident's cephalic region. The IP nurse then flipped the used gauze pad over and continued to wipe the coccyx wound in the same cephalic direction. The Infection Prevention nurse repeated this step with two additional moistened gauze pads; and was observed to flip each gauze pad over during the process to re-wipe the resident's coccyx wound. The clinical record of Resident 34 was reviewed on 2/13/2026 at 10:03 A.M. The resident's diagnoses included but were not limited to: acute on chronic systolic heart failure, diabetes mellitus, dementia, peripheral vascular disease, morbid obesity, hypertensive heart disease, acute on chronic respiratory failure, depression, paranoid schizophrenia, hypothyroidism, anxiety, and agoraphobia with panic disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 12/22/2025, indicated the resident was cognitively intact. A current Physician's Order, dated 1/16/2026, indicated Resident 34 had been placed in Enhanced Barrier precautions (a guideline that requires healthcare staff to wear gowns and gloves during high-contact care activities such as dressing, bathing, transferring, changing linens/briefs, device care for residents with specific risks like chronic wounds or indwelling devices) due to her wounds. A current Physician's Order, dated 2/4/2026, indicated the resident's pressure ulcer was to be cleansed with wound cleanser, patted dry, and collagen and calcium alginate applied to the wound bed and covered with a foam dressing daily and as needed. During an interview, on 2/12/2026 at 12:48 P.M., the IP nurse indicated the gauze used on a resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wound should not have been flipped over and used again to cleanse the resident's wound. 2. During an interview on 2/12/2026 at 2:16 P.M., the IP Nurse indicated the facility had experienced a COVID outbreak in January 2026 but the infection had not been tracked as required. There was no infection surveillance documentation of the COVID outbreak completed. On 2/9/2026 at 1:54 P.M. the ED provided a current policy, dated May 2023 and titled, Coronavirus Disease (COVID 19) - Infection Control and Prevention. The policy indicated, .The infection prevention and control measures that are implemented to address the SARS -CoV-2pandemic are incorporated into the facility infection prevention and control plan. These measures include: c. identifying and managing ill residents and staff On 2/12/2026 at 2:58 P.M., the Administrator provided a policy titled, Standard Precautions, dated 9/2022 and indicated the policy was the one currently used by the facility. The policy indicated .Standard precautions are used in the care of all residents.Hand hygiene refers to handwashing with soap or the use of alcohol-based hand rub (ABHR).Hand hygiene is performed with ABHR or soap and water: before and after contact with the resident; before performing an aseptic task . On 2/12/2026 at 2:58 P.M., the Administrator provided a policy titled, Dressings, dated 9/2013 and indicated the policy was the one currently used by the facility. The policy indicated .If using gauze, use clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually, from the center outward) . 3.1-18(a) 3.1-18(b)(3)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to obtain informed consent for psychotropic medication administration for 5 of 5 residents reviewed for unnecessary medications. (Res 5, 57, B, H & J)Findings include:1.A record review for Resident 5 was completed on 2/13/2026 at 8:49 A.M. Diagnoses included, but were not limited to: anxiety disorder and depression.A Quarterly Minimum Data Set (MDS) assessment, dated 12/22/2025, indicated Resident 5 was cognitively intact and received medication administration of an antianxiety and an antidepressant medication.Physician's Orders, dated 12/15/2025, indicated Resident 5 received desvenlafaxine 50 milligrams daily for depression and buspirone 10 milligrams three times daily for anxiety.A Care Plan, initiated on 9/26/2025, indicated Resident 5 used an antidepressant medication. The goal indicated Resident 5 would be free from discomfort and adverse reactions related to antidepressant therapy.A Care Plan, initiated on 1/16/2026, indicated Resident 5 used an anti-anxiety medication. The goal indicated Resident 5 would be free from discomfort and adverse reactions related to the use of anti-anxiety medication.During an interview, on 2/13/2026 at 11:10 A.M., the Social Service Director (SSD) indicated all notifications and signatures for medication consents had not been obtained until 2/13/2026 after the request for consent documentation had been requested by the survey team.2. A record review for Resident 57 was completed on 2/13/2026 at 9:40 A.M. Diagnoses included, but were not limited to: depression and dementia.A Significant Change MDS assessment, dated 12/11/2025, indicated Resident 57 was not able to be interviewed due to cognitive status and received an antidepressant medication.A Physician's Order, dated 1/16/2026, indicated Resident 57 received Lexapro 5 milligrams daily for depression.A Care Plan, initiated on 10/1/2025, indicated Resident 57 used an antidepressant related to dementia with behavioral disturbances. The goal indicated Resident 57 would be free from discomfort and adverse reactions related to antidepressant therapy.During an interview, on 2/13/2026 at 11:10 A.M., the SSD indicated all verbal notifications for medication consents had not been obtained until 2/13/2026, after the request for psychotropic notification consents had been requested by the survey team.3. A record review for Resident B was completed on 2/12/2026 at 11:15 A.M. Diagnoses included, but were not limited to: dementia, schizoaffective disorder, PTSD (post-traumatic stress disorder), psychotic disorder, generalized anxiety and bipolar disorder.A Quarterly MDS assessment, dated 1/8/2026, indicated Resident B was cognitively intact and received medications including an antipsychotic, an antianxiety, an antidepressant and a hypnotic.Physician's Orders included the following medications:-8/28/2025 Klonopin 0.5 milligrams twice daily for schizophrenia.-10/2/2025 Zyprexa 10 milligrams at bedtime for schizophrenia.-10/10/2025 Ramelteon 8 milligrams as bedtime for insomnia.-1/12/2026 Buspirone 15 milligrams twice daily for anxiety.A Care Plan, initiated on 7/16/2025, indicated Resident B used antipsychotic/antihypnotic medications related to insomnia and schizoaffective disorder. Interventions included, but were not limited to: administer medications as ordered and monitor/report to physician as needed for side effects of the antipsychotic medications.A Care Plan, initiated on 8/25/2025 and revised on 9/2/2025, indicated Resident B used an antianxiety medication. Interventions included, but were not limited to: educate the resident/family/caregivers about risks, benefits and the side effects and/or toxic symptoms of antianxiety medications.During an interview, on 2/13/2026 at 11:08 A.M., Resident B indicated the SSD had just left her room after obtaining informed consent for psychotropic medication use.During an interview, on 2/13/2026 at 11:10 A.M., the SSD indicated she had just had Resident B sign a form regarding informed consent for psychotropic medication use. 4. A record review for Resident H was completed on 2/12/2026 at 8:52 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder and mood adjustment disorder.A Significant Change MDS assessment, dated 12/29/2025, indicated Resident B had moderate cognitive impairment and received an antidepressant medication.A Physician Order, dated 12/17/2025, indicated an order for Cymbalta 20 milligrams daily for depression and an order, on (continued on next page)

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	155073	A. Building B. Wing	02/13/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/30/2026, indicated Ativan 0.5 milligram at bedtime and every four hours as needed for anxiety, A Care Plan, initiated 7/26/2025 and updated on 10/6/2025, indicated Resident H had the potential for depression related to loss of health and independence and a goal of: no signs or symptoms of depression.During an interview, on 2/13/2026 at 11:10 A.M., the SSD indicated all verbal notifications for medication consents had been obtained on 2/13/2026 after the request for psychotropic notification consents had been requested. 5. A record review for Resident J was completed on 2/12/2026 at 2:20 P.M. Diagnoses included, but were not limited to: schizoaffective disorder, mood disorder, major depressive disorder and anxiety disorder.A Quarterly MDS assessment, dated 1/8/2026, indicated Resident H was cognitively intact and received medication of an antipsychotic and an antidepressant.Physician's Orders, dated 12/2/2025 indicated Abilify 10 milligrams twice daily for schizophrenia, Doxepin 10 milligrams at bedtime for depression and sertraline (Zoloft) 50 milligrams 1.5 tablets for depression.A Care Plan, initiated 7/27/2024 and revised on 12/17/2025, indicated Resident H had the potential for depression with the goal of no signs or symptoms of depression.A Care Plan, initiated on 11/18/2024 and revised on 12/17/2025, indicated Resident H used psychotropic medications related to schizoaffective disorder with the goal of no effects from the use of antipsychotic medication.During an interview, on 2/12/2026 at 11:10 A.M., the SSD indicated all verbal notifications for medication consents had been obtained on 2/12/2026 after the request for psychotropic notification had been requested. The SSD indicated it had been hard to get ahold of residents and their resident representatives.A policy for informed consent for psychotropic medications was requested on 2/13/2026 at 11:15 A.M. A policy was not provided prior to the close of the survey.3.1-3(n)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review and interview, the facility failed to ensure 2 of 2 nursing staff (LPN 2 and LPN 3) followed standard pharmacy procedure to ensure accuracy related to documenting medication administration and administering preset medications for 1 of 1 residents observed for dignity. (Resident L)Finding includes:A record review for Resident L was completed, on 2/13/2026 at 10:06 A.M. Diagnoses included, but were not limited to: left femur fracture, diabetes mellitus type 2 and anxiety disorder.An admission Minimum Data Set (MDS) assessment, dated 1/26/2026, indicated Resident L was cognitively intact and received opioid medications for pain.During an interview, on 2/12/2026 at 9:07 A.M., Resident L notified the surveyor team of a concern she had related to her medication administration. Resident L indicated LPN 2 had been very sharp and snippy with her when she had requested her morning medications and pain medication and had not administered her morning medications yet, which included the pain medication that she had requested two hours prior. She indicated LPN 2 had told her that she needed to wait for her medication administration until she had eaten breakfast.A review of the January Medication Administration Record, on 2/12/2026 at 9:27 A.M., indicated all medications, including the as needed pain medication had been signed as administered prior to the time Resident L had notified the survey team of the concern.During an observation, on 2/12/2026 at 9:22 A.M., Resident L returned to her unit and LPN 2 was heard telling Resident L that she had pulled her medications for administration prior to Resident L complaining to the State surveyors.During an interview and observation, on 2/12/2026 at 9:22 A.M., LPN 2 initially indicated she had not signed Resident L's medications as given prior to the administration of the medications. When LPN 2 had been asked why the Medication Administration Record had Resident L's medication recorded as having already been administered, LPN 2 indicated she must have signed the medication as already given. LPN 2 then was observed to hand a souffle cup of of oral medications and two inhalers to LPN 3 to administer to Resident L. LPN 3 went to Resident L's room with the medications, did not verify the medications against the Medication Administration Record (MAR) prior to administering the medications that LPN 2 had handed to her. During an interview, on 2/12/2026 at 9:35 A.M., LPN 3 confirmed she had administered Resident L's medications to her that LPN 2 had handed off to her.During an interview, on 2/13/2026 at 1:24 P.M., QMA 4 indicated medications should not be signed as given prior to administration and another nursing staff should never administer medications prepared by other nursing staff.A policy was provided by the Executive Director, on 2/13/2026 at 2:10 P.M. The policy titled, Medication Administration General Guidelines, indicated, .Preparation or administration of medication[s] or biological completed in accordance with physician's orders; manufacturer's specifications [not recommendations]; accepted professional standards and principles that apply to professionals providing service. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, boards, and councils.Preparation/Administration.c. Medication[s] prepared for on person at a time. i. Medications[s] are administered at time they are prepared. 1. Do not pre-pour or pre-set medication[s]. 2. Do not administer medication[s] prepared by someone else.3.1-25(b)(3)3.1-25(b)(4)

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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. Based on observation, interview and record review, the facility failed to ensure a resident was treated with dignity and respect regarding her concerns with medication administration for 1 of 1 resident reviewed for resident rights. (Resident L)Finding includes:During an interview, on 2/12/2026 at 8:34 A.M., Resident L voiced a concern related to medication administration. Resident L indicated LPN 2 had been very sharp and snippy with her when she had approached the nurse about not administered her morning medications, especially her pain medication that had been requested two hours prior to the complaint . She indicated LPN 2 had told her she needed to wait for her medication administration until she had eaten breakfast.During an observation, on 2/12/2026 at 9:22 A.M., Resident L had returned to her unit and LPN 2 stated to Resident L that she had pulled her medications for administration prior to Resident L complaining to the State surveyors. LPN 2 was argumentative and unkind with Resident L and Resident L had responded with a statement to LPN 2 that she was being snarky. An Incident Report to the Indiana Department of Health was completed for an allegation of abuse, on 2/12/2026 at 10:01 A.M. The allegation indicted Resident L had gone to speak with the Indiana Department of Health Surveyors about LPN 2 refusing to administer scheduled medications and LPN 2 had responded in an unkind manner in the hallway.During an investigation, on 2/12/2026, a statement from LPN 3 indicated she could hear LPN 2 talking loudly to Resident L in the hallway. LPN 3 indicated Resident L felt LPN 2 had been snarky. LPN 3 took Resident L's prepared medications for administration and requested LPN 2 to leave the unit.A record review for Resident L was completed, on 2/13/2026 at 10:06 A.M. Diagnoses included, but were not limited to: left femur fracture, diabetes mellitus type 2 and anxiety disorder.An admission Minimum Data Set (MDS) assessment, dated 1/26/2026, indicated Resident L was cognitively intact and received opioid medications for pain.A Trauma Evaluation assessment, completed on 2/12/2026 at 10:58 A.M., indicated LPN 2 had been snarky when Resident L had requested her medications. The note indicated when Resident L returned to the unit after she had spoken with the IDOH Surveyors, LPN 2 said, I told you I was getting your pills. LPN 2 then gave Resident L's medication to LPN 3 and stated, You give them to her.During an interview, on 2/13/2026 at 1:28 P.M., the Executive Director indicated he expected staff to speak to residents in a kind manner, smile and be helpful. He indicated LPN 2 should not have been argumentative.A policy was provided by the Executive Director, on 2/13/2026 at 10:44 A.M. The policy titled, Resident Rights, indicated, .Employees shall treat all residents with kindness, respect, and dignity.1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness and dignity.This citation relates to intake 2699540. 3.1-3(t)

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	02/13/2026

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consult the physician prior to administration of antihypertensives as instructed in emergency room discharge instructions for 1 of 2 residents reviewed for hospitalizations. (Resident H) This deficient practice resulted in medical-induced hypotension (unwanted low blood pressure caused by medications) and contributed to hospital readmission. In addition the facility failed to notify the physician regarding vital signs outside ordered parameters for blood pressures and blood sugars for 1 of 5 residents reviewed for unnecessary medications. (Resident H) Findings included: 1.The clinical record of Resident H was reviewed on 2/11/2026 at 1:30 P.M. The resident's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, diabetes mellitus, Alzheimer's disease with late onset, depression, chronic fatigue, esophagitis, psoriasis, hypertensive heart disease, dementia, resistant hypertension, chronic diastolic congestive heart failure, atrial fibrillation, chronic kidney disease, hypotension and anxiety. A Significant Change Minimum Data Set (MDS) assessment, dated 12/29/2025, indicated the resident was moderately cognitively impaired. Current Physician orders included, but were not limited to: Torsemide (a loop diuretic water pill) prescribed to reduce excess fluid (edema) caused by heart failure, kidney disease, or liver cirrhosis, and to treat high blood pressure) Oral Tablet 20 milligrams (mg): give 20 mg by mouth one time a day, initiated on 1/6/2025. Metoprolol tartrate (a beta-blocker prescribed to treat high blood pressure) 50 mg tablet: give 3 tablets orally two times a day, initiated on 8/26/2024. A Nursing Progress Note, dated 9/26/2025, at 4:06 A.M., indicated Resident H was sent to the emergency room for an elevated blood pressure of 210/140 mmHg (millimeters of Mercury and a standard unit for measuring blood pressure). An emergency room Discharge summary, dated [DATE], at 7:26 A.M., indicated the resident's visit was for hypertension (high blood pressure or blood pressure greater than 130/80 mm/Hg) and indicated to ask your doctor about the following medications, which included, but were not limited to: Metoprolol tartrate and Torsemide. The Discharge Summary indicated Resident H had been administered Hydralazine (a direct-acting vasodilator used to treat moderate to severe high blood pressure) at 4:59 A.M. and Labetalol (a prescription beta-blocker medication used to treat high blood pressure) at 5:25 A.M. A Nursing Progress Note, dated 9/26/2025, at 8:15 A.M., indicated Resident H had returned from the emergency room and the nurse did not received a report but had noted blood pressure meds[medications].while in ER [emergency room] . A manual blood pressure was recorded as 120/70 mmHg on 9/26/2025 at 8:32 A.M. A Nursing Progress Note, dated 9/26/2025, at 12:40 P.M., indicated Resident H's blood pressure was (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	88/44 mmHg and the resident was difficult to arouse to a sternal rub (a painful, central nervous system stimulus used by healthcare professionals and emergency responders to assess the responsiveness of an unconscious patient). The clinical record failed to evidence any documentation of physician consultation regarding Resident H's scheduled antihypertensive medications prior to their administration. The September 2025 Medication Administration Record indicated Resident H had received her morning doses of Torsemide and Metoprolol on 9/26/2025. A Hospitalist's (a dedicated physician or nurse practitioner who manages the care of patients solely during their hospital stay) History and Physical, dated 9/26/2025, indicated Resident H had been sent back to the emergency room due to her family's concerns regarding her cognitive status. The Hospitalist indicated the patient had continued to receive routine blood pressure medications with subsequent hypotension (low blood pressure). The Hospitalist's History and Physical indicated Resident H met clinical criteria met for sepsis (a life-threatening, emergency response to infection where the immune system damages its own tissues and organs, causing rapid, widespread inflammation) but indicated sepsis was precipitated by medication-induced hypotension and had resulted in acute kidney injury in an elderly individual with chronic kidney disease. A Nurse Practitioner's Note, dated 9/30/2025, indicated Resident H was seen after a hospital stay from 9/26/2025 through 9/29/2025. The Nurse Practitioner indicated Resident H had received 100 mg of Labetalol and 25 mg of Hydralazine and when she had returned to the facility, the resident had received her routine morning medications. Resident H was later found to be somnolent and sent back to the emergency room and diagnosed with sepsis. During an interview, on 2/13/2025 at 3:03 P.M., Employee 3 indicated Resident H had transferred back to this facility from the emergency room on 9/26/2025 and, later that morning, the resident's nurse had administered Resident H's routine blood pressure medications without consulting the physician first. Employee 3 indicated Resident H's nurse had quit working at the facility during the very same shift. During an interview, on 2/13/2025 at 3:45 P.M., the Director of Nursing (DON) indicated the hospital discharge instructions were considered as physician orders and the nurse had not followed the orders when she failed to call the doctor prior to administration of Resident H's routine antihypertensives. 2. A record review for Resident H was completed on 2/12/2026 at 8:52 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, atrial fibrillation, congestive heart failure and hypertension. A Significant Change Minimum Data Set (MDs) assessment, dated 12/29/2025, indicated Resident H had moderate cognitive impairment and received insulin. A Physician's Order, dated 12/17/2025, indicated to notify the physician for a blood pressure greater than 160/80 mmHg (millimeters of mercury). Recorded blood pressure measurements indicated the following blood pressures had not been reported to the physician according to the physician order: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/10/2025 6:32 P.M. 220/100 mmHg -1/19/2026 6:36 P.M. 192/86 mmHg A Physician's Order, dated 11/21/2025 and discontinued on 12/8/2025, indicated Humalog Injection Solution 100 units/milliliters inject eight units subcutaneously three times a day for diabetes mellitus. The Humalog injection should have been held if Resident 19 did not eat breakfast, if the blood sugar readings were below 200 mg/dL (milligrams per deciliter) and notification of the physician of the blood sugar below 200 mg/dL. Recorded blood sugar measurements indicated the following blood sugars had not been reported to the physician according to the physician order: 1/11/21/2025 8:26 A.M. 137 mg/dL -11/21/2025 2:01 P.M. 178 mg/dL -11/25/2025 7:04 A.M. 75 mg/dL -11/27/2025 9:02 A.M. 81 mg/dL -11/28/2025 10:48 P.M. 133 mg/dL -12/2/2025 3:47 P.M. 125 mg/dL -12/3/2025 9:21 A.M. 129 mg/dL -12/4/2025 7:48 P.M. 155 mg/dL -12/5/2025 8:37 A.M. 111 mg/dL A Physician's Order, dated 12/8/2025 and discontinued on 1/6/2026, indicated Humalog Injection Solution 100 units/milliliters inject four units subcutaneously three times a day for diabetes mellitus. The Humalog injection should have been held if Resident 19 did not eat and notify the nurse practitioner if blood sugar readings were below 150 mg/dL. Recorded blood sugar measurements indicated the following blood sugars had not been reported to the nurse practitioner according to the physician order: -12/9/2025 12:26 P.M. 102 mg/dL -12/9/2025 3:30 P.M. 93 mg/dL -12/10/2025 11:17 A.M. 86 mg/dL -12/16/2025 9:32 A.M. 106 mg/dL -12/18/2025 9:11 A.M. 106 mg/dL (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/20/2025 10:06 A.M. 98 mg/dL -12/23/2025 7:43 P.M. 137 mg/dL -12/24/2025 11:00 P.M. 119 mg/dL -12/28/2025 8:33 A.M. 111 mg/dL -12/31/2025 9:36 A.M. 85 mg/dL -12/31/2025 12:44 P.M. 119 mg/dL -1/1/2026 8:34 A.M. 115 mg/dL -1/1/2026 12:27 P.M. 119 mg/dL -1/4/2026 4:16 P.M. 115 mg/dL A Care Plan, initiated on 12/19/2025 and revised on 1/6/2026, indicated Resident H had altered cardiovascular status related to atrial fibrillation, heart failure, hypertension and hyperlipidemia. Interventions included, but were not limited to: vital signs and notify the physician of any abnormal readings. A Care Plan, initiated on 7/28/2024 and revised on 1/13/2026, indicated Resident H had the potential for hypo/hyperglycemia related to type two diabetes mellitus. Interventions included, but were not limited to: Accuchecks (blood sugar assessments) as ordered, call MD for Accuchecks greater than 400 and less than 70 and to provide insulin coverage per resident's individual order. During an interview, on 2/13/2026 at 1:38 P.M., QMA 8 indicated any vital signs beyond the ordered parameters should have resulted in the nurse having been notified for physician notification. During an interview, on 2/13/2026 at 1:44 P.M., LPN 5 indicated if vitals signs were out of range from the physician's order, the physician or nurse practitioner should have been notified. A policy was provided by the Executive Director, on 2/12/2026 at 2:00 P.M. The policy titled, Change in Resident's Condition or Status, indicated, .Our facility promptly notifies the resident, hir or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.1. The nurse will notify the resident's attending physician or physician on call when there has been a[an].i. specific instruction to notify the physician of changes in the resident's condition. On 2/13/2026 at 11:58 A.M., the DON provided an undated policy titled, Charting and Documentation and identified it as the policy currently used by the facility. The policy indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition . 2. The following information is to be documented in the resident medical record: d. changes in the resident's condition On 2/13/2026 at 4:10 P.M., the Director of Nursing (DON) provided a policy titled, Physician Orders, dated 3/17/2022 and indicated the policy was the one currently used by the facility. The policy (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated .The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines. On 2/13/2026 at 4:10 P.M., the DON provided a policy titled, Functional Impairment – Clinical Protocol, dated 2/2014 and indicated the policy was the one currently used by the facility. The policy indicated .whenever a significant change of condition occurs, and periodically during a resident/patient's stay, the physician and staff will assess the resident/patient's function along with their physical condition. 3.1-5(a)(3)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, record review and interview, the facility failed to provide timely assessments related to safe and appropriate use of a bed alarm and failed to document resident/family education and consent for a bed alarm for 1 of 2 residents reviewed for restraints. (Resident 30)Finding includes:During an observation of Resident 30's room on 2/9/2026 at 3:06 P.M., a bed alarm pad could be seen laying on the empty bed with a cord coming off the bed alarm pad and plugged into an alarm near the bed. During random observations of Resident 30 from 2/10/2026-2/13/2026, Resident 30 had not been observed laying in her bed. Resident 30's record review was completed on 2/13/2026 at 1:44 P.M. Diagnoses included, but were not limited to dementia, anxiety disorder, depression, hypertension (high blood pressure) and dysphagia. A Quarterly Minimum Data Set (MDS) assessment, dated 12/11/2025, indicated Resident 30 had severely impaired cognition, had adequate hearing, clear speech, had usually been able to understand others and others usually understood her. Resident 30 had been dependent on staff for all transfers and had used a bed alarm daily. A current Physician's order, initiated on 3/18/2025 indicated Resident 30's bed alarm placement and function should be checked every shift. A current Care Plan, initiated on 10/21/2025, indicated Resident 30 used a bed alarm for enhanced safety and to prevent falls. An intervention, initiated on 10/21/2025 indicated the staff should document any side effect related to the use of the bed alarm in the nursing notes of the resident's medical record and were to check the placement and functionality of the bed alarm every shift. Resident 30's record lacked the documentation to indicate the resident had been assessed for safety related to the bed alarm use before the bed alarm was applied . A Physical Restraint Evaluation, dated 6/20/2025 had been started, but had not been completed. Physical Restraint Evaluations completed on 8/21/2025 and 10/21/2025 indicated restraints were not recommended after the evaluations had been completed. During an interview on 2/13/2025 at 2:04 P.M., Licensed Practical Nurse (LPN) 5 indicated that she had always believed bed alarms were a restraint, but the Director of Nursing had told her bed alarms were not restraints and she had not needed to follow the requirements for restraints. During an interview on 2/13/2025 at 2:10 P.M., the Unit Manager (UM) indicated that she had been educated by her DON that bed and chair alarms were not restraints and had not needed to be assessed. The UM indicated the resident did not have a diagnosis related to having a bed alarm and she believed a diagnosis of falls was not an appropriate diagnoses for which to initiate a bed alarm. The UM indicated the resident had fallen and the family had wanted her to have the alarm because the resident had been on the floor for sometime before staff had found her. However, the UM was not able to provide any documentation the family had requested the bed alarm, had been educated on the use of a bed alarm, or had been agreeable to the bed alarm usage before the exit of the survey on 2/13/2026 at 5:00 P.M. During an interview on 2/13/2025 at 2:30 P.M., the DON indicated the bed alarm was being used because it had made the family feel safer after the resident had had a previous fall at the facility. The DON indicated the bed alarm was not a restraint and they were not using the bed alarm to restrict the resident's movements, but to alert staff that the resident was out of bed. The DON indicated that she had been told by another staff member that bed alarms were not a restraint and staff did not need to complete quarterly evaluations, provide resident/family education or have family's consent documented in the resident's record. On 2/13/2026 at 4:22 P.M., the Executive Director provided an undated policy titled, Use of Restraints and indicated it was the policy currently used by the facility. The policy indicated, .Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience,or for the prevention of falls .6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms .14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.15. Should a resident not be capable of making a decision, the surrogate or sponsor may exercise the right of the use or non-use of a restraint. (Note: The surrogate/sponsor may not give permission to use restraints forthe sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms.) 16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. 17. Care plans for residents in restraints will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s) 3.1-3 (w)3.1-26 (a)3.1-26 (q)3.1-26 (s)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on interview and record review, the facility failed to ensure hand splints to prevent bilateral hand contractures was implemented for 1 of 3 residents reviewed for range of motion. (Resident D) The clinical record for Resident D was reviewed on 2/13/2026 at 10:55 A.M. Diagnosis included, but were not limited to, rheumatoid arthritis and contracture of left and right hand.An Occupational Therapy notes, dated 8/15/2025 through 9/22/2025, provided by the Physical Therapy Director, on 02/13/2026 at 1:40 P.M., indicated current hand splints were appropriate and fit properly and should be continued to be worn at night. A second note, dated 10/08/2025, indicated the resident splints were in good functional order and appropriate for the resident to use. There was no order for the splints in the nursing charting and no documentation that nursing management staff made aware of order.A current Care Plan, initiated on 8/14/2025 with a target date of 2/23/2026, indicated Resident D, had self-care deficits related to joint pain, decreased mobility and rheumatoid arthritis. Interventions included, but were not limited to, physical therapy/occupational therapy evaluation and treatment per medical director orders and treatment plan of care.During an interview with Physical Therapy Director on 2/13/2026 at 1:40 p.m., the Nursing Management staff referred to in the above documentation was clarified to refer the Director of Nursing (DON).During an interview with the DON on 2/13/2026 at 2:34 p.m., she indicated she should have put the order in for bilateral hand splints at night. for Resident D.On 2/13/2026 at 4:10 P.M., the Director of Nursing (DON) provided a policy titled, Physician Orders, dated 3/17/2022 and indicated the policy was the one currently used by the facility. The policy indicated .The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines.On 2/13/2026 at 4:10 P.M., the DON provided a policy titled, Functional Impairment - Clinical Protocol, dated 2/2014 and indicated the policy was the one currently used by the facility. The policy indicated .whenever a significant change of condition occurs, and periodically during a resident/patient's stay, the physician and staff will assess the resident/patient's function along with their physical condition.3.1-42(a)(1)

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	155073	A. Building B. Wing	02/13/2026

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to ensure a the infection control program regarding stewardship of antibiotics was promoted regarding the use of an antibiotic without adequate assessment completed for use for 1 of 1 resident reviewed for antibiotics. (Resident 2)Finding includes:During an interview on 2/12/2026 at 1:59 P.M., the Infection Prevention (IP) Nurse indicated Resident 2 was treated with an antibiotic for a urinary tract infection on 1/4/2026 for 5 days. A urinalysis and/or culture and sensitivity had been ordered on 1/4/2026 to verify the urinary tract infection but was the testing had not been completed as ordered. The IP Nurse further indicated the facility was to utilize the McGreer's criteria to determine the need for an antibiotic but Resident 2's use of an antibiotic had not met the criteria and the physician had not been notified of the issue and lack of criteria to support the use of the antibiotic treatment. On 2/12/2026 at 2:16 P.M. the IP nurse provided a current policy, dated December 2016 and titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes. The policy indicated, .The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interview, the facility failed to ensure the walk-in freezer equipment was in working order for 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 62 of 62 residents who received meals from the kitchen.Finding includes:During an observation of the kitchen, conducted on 2/09/2026 at 9:40 A.M. with the Dietary Manager, the walk-in freezer, located directly outside of the facility, had a large accumulation of ice buildud between the cooling unit of the freezer and the upper southern corner. On of the ice formations was the size and shape of a small watermelon and the other ice formation was the size of a cantaloupe and shaped like an upper cased L letter.During an interview, on 2/9/2026 at 10:00 A.M., the Dietary Manager indicated she had put in a work order weeks ago to get the ice buildup removed from the walk-in freezer. The Dietary Manager indicated the Maintenance Director had told her the freezer could not be fixed until it could be thawed out.During an interview, on 2/11/2026 at 9:05 A.M., the Maintenance Director indicated the ice buildup in the walk-in freezer had been present since he had been hired by the facility, which had been at least over a year. On 2/13/2026 at 3:56 P.M., the Administrator provided a policy titled, Malfunctions and Repairs, dated and 7/2023 the policy was the one currently used by the facility. The policy indicated .All malfunctions and repairs are reported to the food service manager and maintenance department.If repairs require outside help or the purchase of parts, this must be approved per facility policy .3.1 - 19 (bb)