

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  195594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/04/2024
NAME OF PROVIDER OR SUPPLIER  Pilgrim Manor Skilled Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  1524 Doctors Drive Bossier City, LA 71111	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45317</p> <p>Based on record review, video footage review, and interviews, the facility failed to protect the resident's right to be free from deprivation of goods and services by staff for 1 (#1) of 3 (#1, #2, #3) sampled residents when staff failed to utilize a Hoyer lift during a transfer.</p> <p>The deficient practice resulted in an immediate jeopardy for Resident #1 on 11/17/2024 when Resident #1 was transferred from a Geri chair to the bed without utilization of a Hoyer lift. Resident #1 was transferred to a local hospital related to a left lower leg wound which had adipose tissue and bone exposed. Review of Resident #1's hospital record revealed, Resident #1 was admitted with the primary diagnosis type I or II open non-displaced spiral fracture of shaft of left fibula with a laceration to distal LLE (left lower extremity) above the ankle mortis with exposed fibula.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a past noncompliance citation.</p> <p>Findings:</p> <p>Review of Resident #1's hospital record with an admitted [DATE] revealed in part, Resident #1 was admitted with the primary diagnosis type I or II open non-displaced spiral fracture of shaft of left fibula with a laceration to distal LLE above the ankle mortis with exposed fibula. Further review of Resident #1's hospital record revealed Resident #1 underwent incision and debridement surgical intervention to left ankle/leg wound on 11/18/2024 and 11/21/2024 with wound vacuum placement and was discharged on [DATE] to a different local nursing home.</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, cerebral ischemia, polyosteoarthritis, periprosthetic fracture around internal prosthetic left hip joint, Parkinson's disease, and Alzheimer's disease. Review of Resident #1's medical record revealed Resident #1 resided on Hall A in Room A while a resident in the facility. Further review of Resident #1's medical record revealed Resident #1 discharged from the facility on 11/17/2024 and did not return to the facility.</p> <p>Review of Resident #1's MDS (Minimum Data Set) assessment dated [DATE] revealed in part Resident #1 had a BIMS (Brief Interview for Mental Status) score of 8, indicating moderately impaired cognition. Further review of Resident #1's MDS dated [DATE] revealed Resident #1 was totally dependent upon two staff members for transfer.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's physician orders revealed in part:</p> <p>11/24/2023 Resident may be up in Geri chair for trunk control and positioning.</p> <p>10/09/2024 Non-weight bearing to left leg.</p> <p>Review of Resident #1's comprehensive care plan, updated 10/08/2024, revealed Resident #1 required assistance with ADLs (Activities of Daily Living) and was totally dependent in transferring with the use a Hoyer lift.</p> <p>Review of the facility's in-service dated 10/07/2024 included in part, how to use a lift for transfers. Further review of the facility's in-service and attendance record dated 10/07/2024 revealed S5CNA (Certified Nursing Assistant) signed the attendance record dated 10/07/2024.</p> <p>Review of the facility's Incident Report dated 11/17/2024 for Resident #1 revealed Resident #1 was propelled to her room in a Geri chair by S5CNA. S5CNA was in Resident #1's room for about a minute and a half before going to the nurse's station and informing S3RN (Registered Nurse) Supervisor that Resident #1's leg was bleeding. S3RN Supervisor and S4LPN (Licensed Practical Nurse) went to Resident #1's room where Resident #1 was found lying in bed with a laceration to her left leg. Resident #1's Geri chair, with lift pad still present, was observed to be perpendicular to Resident #1's bed. Resident #1 was assessed by S3RN Supervisor and S4LPN, 911 was called, and Resident #1 was transported to hospital. Further review of facility's Incident Report dated 11/17/2024 for Resident #1 revealed local law enforcement was called and transported S5CNA to police station for further questioning related to S5CNA's statement which did not match the facility's video surveillance.</p> <p>Review of S3RN Supervisor's written statement for Resident #1's 11/17/2024 incident revealed: Summoned to room per S5CNA yelling that Resident #1's left leg was cut and bleeding. Found resident in bed lying flat and face up. Resident #1's left lower leg had a laceration measuring 6 inches with adipose tissue and bone exposed. Towels were immediately placed on wound placing adipose tissue back in wound. Blood was noted on floor on right side of Geri chair. Blood was also noted on Geri chair seat, on Geri chair leg rest, lift sling, and 2 screws on the left side of Geri chair foot rest. Geri chair was in a reclined position with brakes applied. Resident #1 was asked what happened and she replied The man in the hall with a bed did it.</p> <p>Review of S5CNA's written statement for Resident #1's 11/17/2024 incident revealed: Resident #1 was in the dining room. I took Resident #1 to her bedroom so I could go get the Hoyer lift machine. When I came back I saw blood everywhere and that is when I went and got the nurse supervisor.</p> <p>Review of facility's video surveillance of hall A dated 11/17/2024 with S1Administrator on 12/03/2024 at 12:00 p.m. revealed:</p> <p>At 2:48 p.m. on 11/17/2024, Resident #1 was observed in Geri chair with legs elevated and resting on Geri chair foot rest. Resident #1 was wheeled down hall A and into Resident #1's room by staff member, who was identified as S5CNA. Further observation failed to reveal any blood on Resident #1's lower extremity clothing or Resident #1's skin which was visible between socks and clothing.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>At 2:49 p.m. on 11/17/2024, S5CNA exited Resident #1's room and walked directly to nurse's station and approached nurse, identified as S3RN Supervisor. S3RN Supervisor walked out of nurse's station and followed S5CNA to Resident #1's room.</p> <p>At 2:50 p.m. on 11/17/2024, S5CNA and S3RN Supervisor, entered Resident #1's room followed by a third staff member, identified as S4LPN.</p> <p>Review of facility's video surveillance from 11/17/2024 of hall A failed to reveal S5CNA left Resident #1's room to obtain a lift. After viewing the facility's video surveillance, S1Administrator reported it was clear in the video that S5CNA never went to get a Hoyer lift as she only left the room once and went directly to the nurse's station.</p> <p>During an interview on 12/02/2024 at 12:45 p.m., S1Administrator reported S5CNA was an agency CNA and had not worked at the facility since the incident on 11/17/2024.</p> <p>During an interview on 12/03/2024 at 9:50 a.m., S6CNA reported she was working hall A with S5CNA on 11/17/2024 at time of Resident #1's incident. S6CNA reported she remembered Resident #1 was a resident who required a Hoyer lift and two persons for transfers.</p> <p>During an interview on 12/03/2024 at 12:05 p.m., S3RN Supervisor reported she remembered the incident on 11/17/2024 involving Resident #1. S3RN Supervisor reported S5CNA came up to her and reported Resident #1's leg was bleeding and S3RN Supervisor followed S5CNA into Resident #1's room. S3RN Supervisor observed Resident #1 lying in bed, face up, with a wound to her lower left leg which had adipose tissue and bone exposed. S3RN Supervisor reported she covered the wound and called 911. S3RN Supervisor reported when she entered Resident #1's room she also observed the Geri chair perpendicular to Resident #1's bed in a reclined position. S3RN Supervisor reported Resident #1's Hoyer lift sling was still in the Geri chair and there was not a Hoyer lift in Resident #1's room. S3RN reported S5CNA stated Resident #1 must have injured her leg herself. S3RN Supervisor further reported prior to being summoned to Resident #1's room, Resident #1 was in her Geri chair in the dining room, which was visible from nurse's station, and S3RN Supervisor had not observed any blood or injury to Resident #1.</p> <p>During a telephone interview on 12/03/2024 at 12:18 p.m., S4LPN reported she remembered the incident on 11/17/2024 involving Resident #1. S4LPN confirmed she was the nurse working hall A on 11/17/2024. S4LPN reported prior to the incident on 11/17/2024, Resident #1 had been in the dining room in her Geri chair and Resident #1 did not have any blood on her or injury.</p> <p>During a telephone interview on 12/04/2024 at 8:25 a.m. S5CNA reported she remembered the incident on 11/17/2024 involving Resident #1 and confirmed she was Resident #1's assigned CNA at the time of the incident. S5CNA reported Resident #1 was in her Geri chair in the dining area and a staff member told her Resident #1 was ready to return to her bed. S5CNA reported she took Resident #1 back to her room in the Geri chair and left Resident #1's room to get the Hoyer lift. S5CNA reported Resident #1 was in the Geri chair and the Geri chair foot rest was pushed up to the side of the bed when she exited the room. S5CNA reported when she went back into Resident #1's room, Resident #1 was in bed with a wound to her leg. S5CNA reported she exited the room again and went to get the nurse.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/04/2024 at 10:30 a.m., S1Administrator reported S5CNA had been in-serviced, knew how to use a lift, and the lift sling was still in Resident #1's Geri chair. S1 Administrator acknowledged S5CNA failed to follow Resident #1's plan of care and utilize a Hoyer lift during transfers.</p> <p>During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>The facility implemented the following actions to correct the deficient practice beginning on 11/17/2024 with a completion date of 11/26/2024:</p> <ol style="list-style-type: none"> <li>1. Nursing staff will be educated in the proper usage of a mechanical lift using 2 staff members by 11/25/2024.</li> <li>2. Nursing staff will be in-serviced on how to access the Kardex in the resident's electronic health record by 11/25/2024.</li> <li>3. All residents who require a mechanical lift will be reassessed by the DON (Director of Nursing) or designee. The QI (Quality Improvement) Nurse will open a retired assessment for quality assurance purpose only. The assessment will then be turned off and the facility will resume the therapy screen by 11/25/2024.</li> <li>4. The DOR (Director of Rehabilitation) was in-serviced on completing therapy screens upon admission, readmission, quarterly, and as needed. As needed screens will be requested after the interdisciplinary team determines the need. QI Nurse completed this on 11/22/2024.</li> <li>5. The DON or designee will evaluate staff members using the mechanical lift or assessing 2 person assist transfers at least 3 days a week for 4 weeks. Any issues found will be addressed immediately, staff educated, and the QAPI (Quality Assurance and Performance Improvement) committee will be notified beginning 11/22/2024.</li> <li>6. A sign was placed at the head of the bed of any resident assisted in transfers with the mechanical lift to remind staff to use the mechanical lift and that it requires two people beginning 11/22/2024 and is ongoing with any changes in Residents' condition or new admissions.</li> <li>7. The DON or designee will monitor that nursing staff, including agency nursing staff, can access the Kardex from the computer by observation of staff retrieval of the data from the electronic health record.</li> <li>8. The Administrator, DON, DOR, MDS staff were in-serviced by QI Nurse on proper completion of therapy screen assessments on 11/26/2024. (Completed prior to surveyor's arrival on 11/26/2024 at 12:55 p.m.)</li> <li>9. The CNA involved in the incident was reported to the CNA board on 11/18/2024 by the Administrator.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45317</p> <p>Based on record review, video footage review, and interviews, the facility failed to ensure a resident received adequate assistance to prevent accidents for 1 (#1) of 3 (#1, #2, #3) residents reviewed for transfers by failing to follow Resident #1's plan of care.</p> <p>The deficient practice resulted in an immediate jeopardy for Resident #1 on 11/17/2024 when Resident #1 was transferred from a Geri chair to the bed without utilization of a Hoyer lift. Resident #1 was transferred to a local hospital related to a left lower leg wound which had adipose tissue and bone exposed. Review of Resident #1's hospital record revealed, Resident #1 was admitted with the primary diagnosis type I or II open non-displaced spiral fracture of shaft of left fibula with a laceration to distal LLE (left lower extremity) above the ankle mortis with exposed fibula.</p> <p>The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined to be a past noncompliance citation.</p> <p>Findings:</p> <p>Review of Resident #1's hospital record with an admitted [DATE] revealed in part, Resident #1 was admitted with the primary diagnosis type I or II open non-displaced spiral fracture of shaft of left fibula with a laceration to distal LLE above the ankle mortis with exposed fibula. Further review of Resident #1's hospital record revealed Resident #1 underwent incision and debridement surgical intervention to left ankle/leg wound on 11/18/2024 and 11/21/2024 with wound vacuum placement and was discharged on [DATE] to a different local nursing home.</p> <p>Review of Resident #1's medical record revealed an admitted [DATE] with diagnoses including, but not limited to, cerebral ischemia, polyosteoarthritis, periprosthetic fracture around internal prosthetic left hip joint, Parkinson's disease, and Alzheimer's disease. Review of Resident #1's medical record revealed Resident #1 resided on Hall A in Room A while a resident in the facility. Further review of Resident #1's medical record revealed Resident #1 discharged from the facility on 11/17/2024 and did not return to the facility.</p> <p>Review of Resident #1's MDS (Minimum Data Set) assessment dated [DATE] revealed in part Resident #1 had a BIMS (Brief Interview for Mental Status) score of 8, indicating moderately impaired cognition. Further review of Resident #1's MDS dated [DATE] revealed Resident #1 was totally dependent upon two staff members for transfer.</p> <p>Review of Resident #1's physician orders revealed in part:</p> <p>11/24/2023 Resident may be up in Geri chair for trunk control and positioning.</p> <p>10/09/2024 Non-weight bearing to left leg.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's comprehensive care plan, updated 10/08/2024, revealed Resident #1 required assistance with ADLs (Activities of Daily Living) and was totally dependent in transferring with the use a Hoyer lift.</p> <p>Review of the facility's in-service dated 10/07/2024 included in part, how to use a lift for transfers. Further review of the facility's in-service and attendance record dated 10/07/2024 revealed S5CNA (Certified Nursing Assistant) signed the attendance record dated 10/07/2024.</p> <p>Review of the facility's Incident Report dated 11/17/2024 for Resident #1 revealed Resident #1 was propelled to her room in a Geri chair by S5CNA. S5CNA was in Resident #1's room for about a minute and a half before going to the nurse's station and informing S3RN (Registered Nurse) Supervisor that Resident #1's leg was bleeding. S3RN Supervisor and S4LPN (Licensed Practical Nurse) went to Resident #1's room where Resident #1 was found lying in bed with a laceration to her left leg. Resident #1's Geri chair, with lift pad still present, was observed to be perpendicular to Resident #1's bed. Resident #1 was assessed by S3RN Supervisor and S4LPN, 911 was called, and Resident #1 was transported to hospital. Further review of facility's Incident Report dated 11/17/2024 for Resident #1 revealed local law enforcement was called and transported S5CNA to police station for further questioning related to S5CNA's statement which did not match the facility's video surveillance.</p> <p>Review of S3RN Supervisor's written statement for Resident #1's 11/17/2024 incident revealed: Summoned to room per S5CNA yelling that Resident #1's left leg was cut and bleeding. Found resident in bed lying flat and face up. Resident #1's left lower leg had a laceration measuring 6 inches with adipose tissue and bone exposed. Towels were immediately placed on wound placing adipose tissue back in wound. Blood was noted on floor on right side of Geri chair. Blood was also noted on Geri chair seat, on Geri chair leg rest, lift sling, and 2 screws on the left side of Geri chair foot rest. Geri chair was in a reclined position with brakes applied. Resident #1 was asked what happened and she replied The man in the hall with a bed did it.</p> <p>Review of S5CNA's written statement for Resident #1's 11/17/2024 incident revealed: Resident #1 was in the dining room. I took Resident #1 to her bedroom so I could go get the Hoyer lift machine. When I came back I saw blood everywhere and that is when I went and got the nurse supervisor.</p> <p>Review of facility's video surveillance of hall A dated 11/17/2024 with S1Administrator on 12/03/2024 at 12:00 p.m. revealed:</p> <p>At 2:48 p.m. on 11/17/2024, Resident #1 was observed in Geri chair with legs elevated and resting on Geri chair foot rest. Resident #1 was wheeled down hall A and into Resident #1's room by staff member, who was identified as S5CNA. Further observation failed to reveal any blood on Resident #1's lower extremity clothing or Resident #1's skin which was visible between socks and clothing.</p> <p>At 2:49 p.m. on 11/17/2024, S5CNA exited Resident #1's room and walked directly to nurse's station and approached nurse, identified as S3RN Supervisor. S3RN Supervisor walked out of nurse's station and followed S5CNA to Resident #1's room.</p> <p>At 2:50 p.m. on 11/17/2024, S5CNA and S3RN Supervisor, entered Resident #1's room followed by a third staff member, identified as S4LPN.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of facility's video surveillance from 11/17/2024 of hall A failed to reveal S5CNA left Resident #1's room to obtain a lift. After viewing the facility's video surveillance, S1Administrator reported it was clear in the video that S5CNA never went to get a Hoyer lift as she only left the room once and went directly to the nurse's station.</p> <p>During an interview on 12/03/2024 at 9:50 a.m., S6CNA reported she was working hall A with S5CNA on 11/17/2024 at time of Resident #1's incident. S6CNA reported she remembered Resident #1 was a resident who required a Hoyer lift and two persons for transfers.</p> <p>During an interview on 12/03/2024 at 12:05 p.m., S3RN Supervisor reported she remembered the incident on 11/17/2024 involving Resident #1. S3RN Supervisor reported S5CNA came up to her and reported Resident #1's leg was bleeding and S3RN Supervisor followed S5CNA into Resident #1's room. S3RN Supervisor observed Resident #1 lying in bed, face up, with a wound to her lower left leg which had adipose tissue and bone exposed. S3RN Supervisor reported she covered the wound and called 911. S3RN Supervisor reported when she entered Resident #1's room she also observed the Geri chair perpendicular to Resident #1's bed in a reclined position. S3RN Supervisor reported Resident #1's Hoyer lift sling was still in the Geri chair and there was not a Hoyer lift in Resident #1's room. S3RN reported S5CNA stated Resident #1 must have injured her leg herself. S3RN Supervisor further reported prior to being summoned to Resident #1's room, Resident #1 was in her Geri chair in the dining room, which was visible from nurse's station, and S3RN Supervisor had not observed any blood or injury to Resident #1.</p> <p>During a telephone interview on 12/03/2024 at 12:18 p.m., S4LPN reported she remembered the incident on 11/17/2024 involving Resident #1. S4LPN confirmed she was the nurse working hall A on 11/17/2024. S4LPN reported prior to the incident on 11/17/2024, Resident #1 had been in the dining room in her Geri chair and Resident #1 did not have any blood on her or injury.</p> <p>During a telephone interview on 12/04/2024 at 8:25 a.m. S5CNA reported she remembered the incident on 11/17/2024 involving Resident #1 and confirmed she was Resident #1's assigned CNA at the time of the incident. S5CNA reported Resident #1 was in her Geri chair in the dining area and a staff member told her Resident #1 was ready to return to her bed. S5CNA reported she took Resident #1 back to her room in the Geri chair and left Resident #1's room to get the Hoyer lift. S5CNA reported Resident #1 was in the Geri chair and the Geri chair foot rest was pushed up to the side of the bed when she exited the room. S5CNA reported when she went back into Resident #1's room, Resident #1 was in bed with a wound to her leg. S5CNA reported she exited the room again and went to get the nurse.</p> <p>During an interview on 12/04/2024 at 10:30 a.m., S1Administrator reported S5CNA had been in-serviced, knew how to use a lift, and the lift sling was still in Resident #1's Geri chair. S1 Administrator acknowledged S5CNA failed to follow Resident #1's plan of care and utilize a Hoyer lift during transfers.</p> <p>During the survey, in-service records and Quality Assurance (QA) monitoring records were reviewed and it was determined that the facility had implemented the following corrective actions to correct the deficient practice prior to entering the facility.</p> <p>The facility implemented the following actions to correct the deficient practice beginning on 11/17/2024 with a completion date of 11/26/2024:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<ol style="list-style-type: none"> <li>1. Nursing staff will be educated in the proper usage of a mechanical lift using 2 staff members by 11/25/2024.</li> <li>2. Nursing staff will be in-serviced on how to access the Kardex in the resident's electronic health record by 11/25/2024.</li> <li>3. All residents who require a mechanical lift will be reassessed by the DON (Director of Nursing) or designee. The QI (Quality Improvement) Nurse will open a retired assessment for quality assurance purpose only. The assessment will then be turned off and the facility will resume the therapy screen by 11/25/2024.</li> <li>4. The DOR (Director of Rehabilitation) was in-serviced on completing therapy screens upon admission, readmission, quarterly, and as needed. As needed screens will be requested after the interdisciplinary team determines the need. QI Nurse completed this on 11/22/2024.</li> <li>5. The DON or designee will evaluate staff members using the mechanical lift or assessing 2 person assist transfers at least 3 days a week for 4 weeks. Any issues found will be addressed immediately, staff educated, and the QAPI (Quality Assurance and Performance Improvement) committee will be notified beginning 11/22/2024.</li> <li>6. A sign was placed at the head of the bed of any resident assisted in transfers with the mechanical lift to remind staff to use the mechanical lift and that it requires two people beginning 11/22/2024 and is ongoing with any changes in Residents' condition or new admissions.</li> <li>7. The DON or designee will monitor that nursing staff, including agency nursing staff, can access the Kardex from the computer by observation of staff retrieval of the data from the electronic health record.</li> <li>8. The Administrator, DON, DOR, MDS staff were in-serviced by QI Nurse on proper completion of therapy screen assessments on 11/26/2024. (Completed prior to surveyor's arrival on 11/26/2024 at 12:55 p.m.)</li> <li>9. The CNA involved in the incident was reported to the CNA board on 11/18/2024 by the Administrator.</li> </ol> <p>The QAPI committee will review this plan weekly for four weeks, then monthly, and as needed after that to make certain the plan is being implemented, functioning, and appropriate to meet the needs of the residents in the facility.</p>		