STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195594	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Manor Skilled Nursing and Rehabilitation	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44414 45317 Based on record reviews, observations and interviews, the facility failed to provide services that met professional standards for 2 (#102, #105) of 26 sampled residents. The facility failed to ensure safe oral medication administration practices by leaving medication at the bedside. Findings: Review of the facility's policy Administering Oral Medications with a revision date of October 2010 revealed in part: Purpose: The purpose of this procedure is to provide guidelines for the safe administration of oral medications. Preparation: 21. Remain with the resident until all medications have been taken. Resident #102 Review of Resident #102's medical record revealed an admitted 07 /11/2023 with a diagnosis including, but not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of Resident #102's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) of 15 indicating intact cognition. An observation on 12/15/2024 at 8:35 a.m. revealed a medicine cup with one pinkish colored pill and four white colored pills on Resident #102's bedside table. During an interview on 12/15/2024 at 8:35 a.m., Resident #102 reported the nurse left her medications on her table for her to take after she finished eating. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/15/2024 at 8:40 a.m. S4LPN (Licensed Practical Nurse) confirmed she left Resident #102's medications in a medication cup at the bedside. S4LPN further confirmeded Resident #102 did not have an order for self-administration of medications. S4LPN reported medications should not have been left at Resident #102's bedside. During an interview on 12/15/2024 at 9:20 a.m. S11RN (Registered Nurse) confirmed a resident must have an order to leave medications at bedside for a resident to take on their own. During an interview on 12/17/2024 at 11:00 a.m. S3DON (Director of Nursing) confirmed Resident #102 did not have an order for self-administration, and medications should not have been left at the bedside. Resident #105 Review of Resident #105's medical record revealed an admitted [DATE] with a diagnosis including, but not limited to malignant neoplasm of the right kidney. Review of Resident #105's annual MDS assessment dated [DATE] revealed a BIMS of 15 indicating intact cognition. An observation on 12/15/2024 at 11: 20 a.m. revealed a medicine cup on Resident #105's bedside table containing one small white pill and one small pink pill. During an interview on 12/15/2024 at 11:20 a.m., Resident #105 reported the pills were left there this morning and he fell asleep before he could take them. Resident #105 stated that is my Oxycodone and my Lexapro. During an interview on 11/15/2024 at 11:25 a.m., S10 LPN confirmed the pills in the medicine cup on Resident #105's bedside were Lexpro and Oxycodone from the morning medication pass. S10LPN acknowledged she left Resident #105's room before Resident #105 had taken his medications. During an interview on 12/15/2024 at 11:45 a.m., S2Corporate Nurse, reported Resident #105 did not have an order for self-administration. S2Corporate Nurse acknowledged medications should not have been left at the bedside and a nurse should stay at the bedside until medication administration has been completed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37867 Based on observations, interviews, and record reviews, the facility failed to provide respiratory care consistent with professional standards of practice for 2 (#27, #224) out of 2 (#27, #224) residents reviewed for respiratory services. The facility failed to: 1. Change the humidification bottle and nasal cannula weekly as ordered for Resident #27, and 2. Ensure oxygen tubing was dated, and humidification was administered with oxygen for Resident #224. Findings: Review of facility policies related to oxygen therapy revealed in part: Department (Respiratory Therapy)-Prevention of Infection (revised November 2011): Use distilled water for humidification per facility protocol. [NAME] bottle with date and initials upon opening . Oxygen Administration (Revised October 2010)-The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .The following equipment and supplies will be necessary when performing this procedure. 1) portable oxygen cylinder or concentrator 2) nasal cannula, nasal catheter, mask (as ordered), 3) humidifier bottle . Resident #27 Review of Resident #27's medical record revealed an admitted [DATE], and diagnoses including but not limited to: other sequelae of cerebral infarction, generalized anxiety disorder, unspecified dementia, shortness of breath, and atrial fibrillation. Review of Resident #27's current physician's orders as of 12/16/2024 included: -an order dated 02/16/2023-oxygen-may have oxygen at 2 liters per nasal cannula or mask related to shortness of breath -an order dated 06/14/2024-oxygen: change mask, O2 (oxygen) tubing, water bottle, and clean concentrator filter every Friday night shift Observation on 12/15/2024 at 10:20 a.m. revealed Resident #27's humidification bottle with attached cannula were dated 12/01/2024. Observation on 12/16/2024 at 8:20 a.m. revealed Resident #27's oxygen humidification bottle with attached nasal cannula was dated 12/01/2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/16/2024 at 8:25 a.m. S9 LPN (Licensed Practical Nurse) viewed Resident #27's oxygen set up and confirmed the humidification bottle with attached nasal cannula was dated 12/01/2024. S9 LPN further confirmed the set up should be changed weekly and had not been. Resident #224 Review of Resident #224's medical record revealed an admitted [DATE], and diagnoses including but not limited to sepsis and dependence on supplemental oxygen. Review of Resident #224's current physician's orders as of 12/16/2024 revealed orders including: -an order dated 12/13/2024-oxygen: administer continuous oxygen at 3L/NC (liters per nasal cannula) -an order dated 12/13/2024-oxygen: change mask, O2 tubing, water bottle and clean concentrator filter every day shift every Saturday. Observation on 12/15/2024 at 10:10 a.m. revealed Resident #224 had oxygen in use at 3L/NC connected to concentrator with no humidification bottle and no date on cannula tubing. Observation on 12/16/2024 at 8:20 a.m. revealed Resident #224 had oxygen in use at 3L/NC connected to concentrator with no humidification bottle and no date on cannula tubing. During an interview on 12/16/2024 at 8:25 a.m. S9 LPN viewed Resident #224's oxygen setup and confirmed there was no humidification and no date on the cannula tubing and there should be.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 37867 Based on observations and interviews, the facility failed to ensure dietary services were provided in a safe, sanitary environment to prevent contamination and food borne illness for the 121 residents served a meal tray from the kitchen per the Dietary Manager. The facility failed to ensure frozen meat was thawed following accepted practices. Findings: Observation in the facility kitchen on 12/15/2024 at 7:50 a.m. revealed 2 large tube shaped chubs of ground beef in plastic packing and 3 large tube shaped pork tenderloins in plastic packing submerged in standing water in the sink. During an interview on 12/15/2024 at 7:58 a.m. S7 [NAME] confirmed the meat should be thawing under running water, and should not be submerged in standing water. S7 [NAME] further reported the pork tenderloin was for the day's lunch, and the ground beef was for spaghetti for supper. During an interview on 12/15/2024 at 8:32 a.m. S6 Dietary Manager confirmed meat should be thawed under running, not standing, water. Observation in the facility kitchen on 12/16/2024 at 8:13 a.m. revealed multiple loose pork chops, out of packaging, along with ground beef in a zip lock bag thawing in a sink full of standing water. During an interview on 12/16/2024 at 8:15 a.m. S8 [NAME] confirmed the meat should be thawed under running, not standing, water. S8 [NAME] further reported she did not know how the sink was cleaned before the meat was placed in direct contact with the sink. During an interview on 12/16/2024 at 3:27 p.m. S6 Dietary Manager reported there were 121 residents served meal trays from the kitchen on 12/15/2024 and 12/16/2024.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 30115 Based on record review and interview, the facility failed to electronically submit accurate payroll information for direct care staffing as required. Findings: Review of the PBJ (Payroll Based Journal) Staffing Data Report for FY (Fiscal Year) Quarter 4 2024 (July 1-September 30) revealed triggers for the following: One Star Staffing Rating and Excessively Low Weekend Staffing. During an interview on 12/16/2024 at 11:30 a.m. S5 Regional [NAME] President acknowledged, for the FY Quarter 4 2024 (July 1 - September 30), there was a PBJ system reporting error to CMS (Center for Medicaid and Medicare Services) for staffing.