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	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Manor Skilled Nursing and Rehabilitation	1524 Doctors Drive Bossier City, LA 71111

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to follow physician's orders for 1 (Resident #47) of 1 (Resident #47) resident reviewed for UTI. Findings: Review of Resident #47's medical record revealed an admit date of 09/26/2017 with a re-entry date of 11/22/2021. Resident #47 had diagnoses which included in part type 2 diabetes, postmenopausal atrophic vaginitis, unilateral primary osteoarthritis of the right hip and polyneuropathy. Review of Resident #47's Quarterly MDS dated [DATE] revealed in part a BIMS score of 15, indicating intact cognition. Review of Resident #47's comprehensive care plan revealed in part, Resident #47 was frequently to always incontinent of bowel and bladder with interventions initiated on 05/07/2024 to monitor for s/sx of UTI: pain, burning, and urinary frequency. Review of Resident #47's physician orders revealed an order dated 07/23/2025 for estradiol vaginal cream 0.1 mg/gm 1 application vaginally q day for vaginal irritation related to postmenopausal atrophic vaginitis. Review of Resident #47's February 2026 MAR reveal in part, estradiol vaginal cream was not documented as administered on the following dates: 02/01/2026, 02/04/2026, 02/05/2026, 02/09/2026, 02/10/2026, 02/11/2026, 02/12/2026, 02/13/2026, 02/15/2026, 02/16/2026, 02/18/2026, 02/19/2026, 02/21/2026, 02/22/2026, and 02/23/2026. During an interview on 02/23/2026 at 11:20 a.m., Resident #47 reported S7MD had put her on the vaginal cream to help with the burning and itching. Resident #47 further reported she had not gotten the vaginal cream in months and was in 8.5-9 out of a 10 pain level when she voided. During an interview on 02/24/2026 at 9:20 a.m., S8ADON reviewed Resident #47's February 2026 MAR and acknowledged Resident #47 had not received the daily dose of vaginal cream and should have. During an interview on 02/24/2026 at 12:55 p.m., S7MD reported estradiol cream was to be administered to Resident #47 daily and stated Resident #47 has severe atrophic vaginitis. S7MD acknowledged nursing staff had not administered the vaginal cream daily as ordered. During an interview on 02/24/2026 at 12:00 p.m., S1DON acknowledged Resident #47 had not received daily doses of estradiol cream as ordered and should have.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on medication administration observations, record reviews, and interviews, the facility failed to ensure the facility was free from a medication error rate of 5% or greater. The facility had a 14.29% medication error rate with 4 medication errors out of 28 opportunities.Findings: Resident #19 Observation of the medication pass for Resident #19 on 02/23/2026 at 8:15 a.m. revealed S2LPN administered 13 oral medications to Resident #19. Review of Resident #19's current physician orders and MAR revealed Resident #19 had not received the following medications during medication pass, which were due on 02/23/2026 at 9:00 a.m.: Fluticasone propionate 50 mcg/at 1 spray in each nostril bidOlopatadine hcl solution 0.1% 1 drop in right eye q dayCyclosporine emulsion 0.05% 1 drop in both eyes bid During an interview on 02/23/2026 at 11:10 a.m. S2LPN acknowledged she administered fluticasone propionate, olopatadine hcl and cyclosporine emulsion to Resident #19 after medication pass observations had been completed. S2LPN acknowledged she should have notified surveyor to observe the administrations and did not. Resident #47 Observation of the medication pass for Resident #47 on 02/23/2026 at 8:08 a.m. revealedS2LPN administered 11 oral medications to Resident #47. Review of Resident #47's current physician orders and MAR revealed Resident #47 had not received the following medication during medication pass, which were due on 02/23/2026 at 9:00 a.m.: Estradiol vaginal cream 0.1 mg/gm 1 application vaginally q day During an interview on 02/23/2026 at 11:10 a.m., S2LPN acknowledged she administered estradiol vaginal cream to Resident #47 after medication pass observations had been completed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record reviews and interview the facility failed to inform and provide written information to residents or resident's representative concerning the right to formulate an advance directive for 2 (#38, #96) of the 48 sampled residents. Findings:Review of facility's policy titled Advance Directives with revision date of 05/31/2023 revealed in part:Policy StatementAdvance directives will be respected in accordance with state law and facility policy.Policy Interpretation and Implementation1. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Resident #38 Review of Resident #38's medical record revealed an date of 02/17/2025. Further review of Resident #38's medical record failed to reveal resident or resident's representative was provided with written information concerning advance directives. During an interview on 02/24/2026 at 2:53 p.m., S3admission Coordinator reported it was the facility's policy to provide printed material regarding advance directives upon admission. S3admission Coordinator confirmed she could not locate documentation Resident #38 was provided with written information concerning advance directives upon admission. Resident #96 Review of Resident #96's medical record revealed an date of 07/15/2024. Further review of Resident #96's medical record failed to reveal resident or resident's representative was provided with written information concerning advance directives. During an interview on 02/24/2026 at 2:53 p.m., S3admission Coordinator reported it was the facility's policy to provide printed material regarding advance directives upon admission. S3admission Coordinator confirmed she could not locate documentation Resident #96 was provided with written information concerning advance directives upon admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to revise the care plan to reflect changes of a resident refusing medication/treatment for 1 (#31) of 1 sampled resident reviewed for care planning.Findings:Review of Resident #31's record revealed an admission date of 09/02/2020 with the following diagnoses which included but not limited to: Muscle wasting atrophy, Chronic Obstructive Pulmonary Disease, Mild protein-calorie malnutrition; and unspecified dementia.Review of Resident #31's Quarterly MDS dated [DATE] revealed a BIMS of 13 indicating intact cognition. Further review revealed under Section E: Rejection of Care was coded 0 indicating the behavior was not exhibited.Review of Resident #31's Discharge MDS dated [DATE] revealed under Section E: Rejection of Care was coded a 0 indicating the behavior was not exhibited. Review of Resident #31's Physician Order dated 06/18/2024 revealed an order for Estrace Vaginal Cream 0.1 milligram/gram, insert 1 application vaginally at bedtime.Review of Resident #31's January and February 2026 MAR revealed Resident #31 refused Estrace vaginal cream on the following dates in January: 2 - 4, 6-14, 16-20, 26, 28, 30 and 31. Further review revealed Resident #31 refused Estrace vaginal cream on the following dates in February: 1, 2, 10-14, 16, 17, 20, 22, 23 and 24. During an interview on 02/25/2026 at 10:28 a.m. S1DON reported if a resident consistently refuses medication/treatment, their care plan should be reviewed and revised to include refusal of medication/treatment.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review the facility failed to provide nutritional and hydration care and services for 1(#57) of 5 (#4, #7, #13, #14 and 57) resident reviewed for nutrition. The facility failed to provide care and services for resident #7 consistent with the resident's comprehensive assessment resulting in weight loss.Findings: Review of Resident #57's Comprehensive Plan of Care dated 05/17//2025 revealed Resident #57 had an ADL self-care performance deficit related to cerebral vascular accident times two, other symptoms and signs involving cognitive functions following cerebral infarction, vision loss. Eating, resident requires supervision to touch assistance with eating due to blindness, CVA.Review of Resident #57's record revealed diagnoses which included visuospatial deficit and spatial neglect following cerebral infarction, need for assistance with personal care, other lack of coordination and transient cerebral ischemic attack.Review of Resident #57's most recent Quarterly MDS dated [DATE] revealed Section C- cognitive pattern a BIMS score of 11 which indicated moderately impaired. Section GG - Functional Abilities Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident. Requires supervision or touch assistance.Review of the facility's weights for Resident #57's revealed a 6.12-pound weight loss in one month. January 07, 2026 = 176.4 and February 09, 2026 = 165.6.Review of Resident #57; current Physician orders revealed an` order dated 11/14/2025 Regular/Enhanced diet. Regular texture, Regular consistencyReview of the S5 RD documentation dated 02/23/2026 regarding Resident #57 weight loss revealed in part: Resident #57 with no chewing/swallowing difficulty at this time. Resident reported having a good appetite and reports he needs help during mealtimes. Noted resident with signs symptoms of subcutaneous fat loss to orbital region and muscle wasting to temples and hands. Recommendation: Recommend providing resident with total assistance during mealtimes.During an interview 02/23/2026 at 1:00 p.m. Resident #57 reported he did not know what he had to eat, because he was blind and unable to see his food. Resident #57 reported no one had told him what was on his plate.Observation on 02/23/2026 at 1:00 p.m. Resident #57 attempting to feed himself. Resident #57's plate had a small bowl of corn, green peas, ice cream, rice, iced tea and water. Observed Resident #57 trying to place the corn on his spoon. Resident #57 was unable to gather any of the food on his spoon.During an interview on 02/23/2026 at 1:20 p.m.S5 RD agreed Resident #57 should have had assistance with his meals. During an interview on 02/23/2026 at 1:20 p.m. S6 CNA entered Resident #57's room to pick up his meal tray. S6 CNA reported Resident #57 can feed himself. Observation on 02/23/2026 at 1:20 p.m. Resident #57 had covered his plate of food. When asked if he had eaten enough, Resident #57 reported he could not see the food to eat it.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to use infection control standards of practice for 1(#7) of 5 (#4, #7, #13, #14 and 57) residents reviewed for nutrition by not providing proper placement of a resident's gastrostomy tubing to prevent an increased risk of contamination and infection. Resident #7's gastrostomy tubing with the cap or cover was attached to the feeding pump tubing laying on the floor.Observation on 02/23/2026 at 12:50 p.m. with S4 LPN revealed Resident #7's PEG tube was disconnected. The gastrostomy tubing extended from Resident #7's abdomen did not have a cap or cover; it was opened. The cap or cover attached to the feeding pump tubing laying on the floor. S4 LPN removed the cap or cover from the floor and attached it to Resident #7's gastrostomy tube.During an interview on 02/23/2026 at 12:50 p.m. S4 LPN reported she would have to change the tubing later.Review of Resident #7's record revealed diagnoses which included gastrostomy status, dysphagia, right hemiplegia, cerebral ischemia, type 2 diabetes, aphasia, gastroenteritis, and cerebrovascular disease.Review of Resident #7's Physician orders revealed an order dated 02/09/2025 nursing intervention: implement and maintain enhanced barrier precautions when performing high contact care activities, every shift for wounds and PEG tube.Review of Resident #7's annual MDS dated [DATE] revealed cognitive pattern as severely impaired. Functional abilities impaired on one side of upper extremities and impaired on both sides of lower extremities.Review of Resident #7 Comprehensive Plan of Care revealed resident requires PEG feeding related to dysphagia following a cerebral infarction. Resident #7 received nothing by mouth. Resident will remain free of side effects or complications related to tube feeding through next review. Resident's insertion site will be free of signs/symptoms of infection through the next review.