STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PILGRIM MANOR	222 PARKVIEW ST PLYMOUTH, IN 46563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 18, 19, 20, 21, and 22, 2023 Facility number: 000030 Provider number: 155073 AIM number: 100275260 Census Bed Type: SNF/NF: 53 SNF: 4 Total: 57 Census Payor Type: Medicare: 4 Medicaid: 36 Other: 17 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/28.23.	F 0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during this inspection. I would like to formally request your consideration for granting this facility paper compliance, Pilgrim Manor submits this plan of correction (POC) in accordance with specific regulatory requirements. The submission of the POC does not indicate an admission by Pilgrim Manor that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Pilgrim Manor. The Medical Director, Byron M. Holm has reviewed the 2567 and the Plan of Correction. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact myself, Lori A. Smith, Administrator at 574-936-9943.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori A. Smith	Administrator	01/11/2024

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	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or			

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to develop a care plan for a resident with aspiration/choking risk and a resident with a pressure ulcer for 2 of 19 residents reviewed for comprehensive care plans. (Residents 42 & 154) Findings include: 1. A record review for Resident 42 was completed on 12/21/2023 at 9:48 A.M. Diagnoses included, but were not limited to: dementia and history of transient ischemic attack/cerebral infarction. A Quarterly Minimum Data Set (MDS) assessment, dated 8/11/2023, indicated Resident 42 required setup or clean-up assistance with eating. A Nurse's Note, dated 10/2/2023 at 8:09 P.M., indicated Resident 42 was sent to the hospital for evaluation due to coughing, gurgling, and keeping secretions in her mouth. The resident was suctioned with a moderate amount of secretions and bits of food particles. She felt better after the suctioning, but the episode started again in 15 minutes. She was suctioned again and swallowed a sip of water. She stated that something was stuck. The Heimlich maneuver was attempted, but the resident started screaming, "Stop!! It hurts!! Ah!! Stop!!" The Heimlich maneuver was held immediately, and suctioning was continued. The physician was contacted, and an order was received to send Resident 42 to the Emergency Room due to risk of aspiration.	F 0656	1 1. (1) Resident 42 had the potential to be affected by this alleged deficient practice; however, was not affected by this alleged deficient practice. The care plan for resident 42 has been updated and changed to reflect “potential to get foods/liquids into lungs r/t Dementia, manifested by hx of choking” (See Exhibit 1). (2)Resident 154 had the potential to be affected by this alleged deficient practice; however, was not affected by this alleged deficient practice. The care plan was updated to reflect the type of wound and location (See Exhibit 2). The pressure area was healed on 1/9/24. 1.(1) An audit was conducted for all residents on 1-5-24 (See Exhibit 3), to identify any resident who has a risk for aspiration and/or choking. There were 11 other residents identified at risk for aspiration or choking. Care plans have been reviewed and updated See Exhibit 4). There weren’t any residents affected by this alleged deficient practice. (2 An audit was conducted for all residents with pressure ulcers. There is one (1) resident with a pressure ulcer. The care plan has been updated (See Exhibit 5), to reflect the type of wound and	01/15/2024

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	A Nurse's Note, dated 10/2/2023 at 10:30 P.M., indicated a call was placed to the physician, and he was informed that Resident 42 appeared to have a food bolus somewhere in her esophagus. The nurse informed the physician of her prior attempts of treatment for the coughing and gurgling when talking. An Emergency Room Note, dated 10/2/2023, indicated Resident 42 came by EMS (Emergency Medical Services) with a history of aspiration. She apparently choked on dinner and then the facility staff suctioned food chunks out of her hypopharynx. Resident 42 had gurgling respirations, although no desaturations (drop in oxygen level). Resident 42 was complaining of increased respiratory secretions and shortness of breath. The Emergency Room physician's respiratory assessment indicated respirations were labored with gurgling tubular hypopharyngeal sounds, and she was unable to cough out her secretions. The Hospital Admission History and Physical, dated 10/2/2023, indicated Resident 42 presented with aspiration. Resident 42, with a history of aspiration, was brought to the Emergency Room after choking on dinner. The facility staff had to suction food stuff out of hypopharynx after a choking episode. Resident 42 then developed gurgling respirations. A diagnosis of aspiration pneumonia was given. An addendum to the history and physical indicated the physician was called due to increased respiratory distress. Vital signs reported included blood pressure 192/99, pulse 110-120, oxygen saturations in the eighties on five liters of oxygen. On examination Resident 42 had increased shortness of breath, and coarse breath sounds throughout. At 5:00 A.M., Resident 42 had improved some with oxygen		location and physician orders have been reviewed. The resident was not affected by this alleged deficient practice. 1 3. Nursing staff have been in-service on Interdisciplinary Care plans on 1-9, 1-10 and 1-11-24 (See Exhibit 6). Special attention to ensuring care plan is individualized toward each resident. IDT has reviewed all residents at risk for aspiration, choking and pressure areas, to ensure care plans are individualized- IDT team consist of Administrator, Social Services, DON, MDS, IP nurse and all 3 Unit Managers. 2 4. All residents at risk for choking/aspiration and pressure ulcers will have care plans in place. If the electronic medical record has documentation of swallowing difficulties, it will automatically write a care plan (See Exhibit 7), if one is not already in place. The care plan will show up once per week on the Unit Manager audit report (See Exhibit 8). The Unit Manager will review the care plan and make adjustments as needed. New admissions and Readmissions will be reviewed by the Unit Manager on their Admission Audit (See Exhibit 9) for choking/aspiration. The Unit Manager Weekly Audit Report & Admission Audit will be reviewed at the Weekly QAPI meeting (See Exhibit 10). All new	

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	saturations at 91 percent on fifteen liters of oxygen. A Nurse's Note, dated 10/4/2023 at 2:09 P.M., indicated Resident 42 was readmitted to the facility with aspiration pneumonia, and she can resume her normal diet. A Physician's Order, on 10/4/2023, indicated Resident 42's diet changed from a regular diet to a mechanical soft diet. During an interview on 12/22/2023 at 10:15 A.M., the Director of Nursing indicated she could not find a care plan in place for the risk of aspiration and choking for Resident 42. 2. During an interview on 12/19/2023 at 1:57 P.M., Resident 154 and her daughter indicated the resident had a sore on her butt cheek. A record review was conducted on 12/19/23 at 2:57 P.M. The Admission Minimum Data Set (MDS) assessment indicated Resident 154's cognition was intact, was always continent of bowel and bladder and had one stage 2 pressure ulcer and was receiving treatment. Resident 154's diagnoses included, but were not limited to, displaced subtrochanteric fracture of the femur. Current Physician's Orders included, but were not limited to, zinc oxide topical 20% to open area on coccyx twice a day, ordered on 12/4/2023. A Care Plan, dated 12/2/2023, indicated broken or damaged skin related to limited ability to move around. The goal was for the resident to have no skin breakdown for 3 weeks. Interventions included, but were not limited to:		pressure ulcers, including admission/readmission will be reviewed in (PUPP) pressure ulcer prevention plan meeting (See Exhibit 11 policy), to ensure that pressure ulcers are care planned and include location and type. The PUPP documentation will include reviewing care plans for stage, type and location (See Exhibit 12). This will continue to be monitored in our monthly (See Exhibit 13) and quarterly QAPI meetings until the committee has determined that substantial compliance has been achieved, at least 6 to 12 months. The POC was reviewed in the Quarterly QAPI meeting on 1-11-2024. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Records, Pharmacist, Medical Director, Social Services, Unit Managers, Dietary Manager, Business Office Manager, Environmental Services, Maintenance Director, Staff Development, Infection Preventionist, MDS, Activity Director and rotating floor staff.	

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	encourage good nutritional intake, consult with physician/nurse practitioner as needed, reposition hourly when in the wheelchair, and a pressure relieving cushion in the wheelchair. The Care Plan problem did not indicate the type of wound or where it was located. There were no other problems regarding skin noted in the record. A Weekly Skin Assessment, done 12/19/2023, indicated a stage 2 pressure ulcer on the resident's coccyx which had worsened and become larger in width. During an interview on 12/20/2023 at 10:25 A.M., RN 3 indicated on the care plan, there was a problem for broken or damaged skin, but the problem did not include specifics about the wound location, type, or stage. She would have to ask if the care plan should have had that information. During an interview on 12/22/2023 at 10:23 A.M., the Director of Nursing (DON) indicated the care plan was not personalized for the resident's stage 2 wound and should have been. On 12/22/2023, the DON provided a current policy titled, "Interdisciplinary Care Plan" effective as of 3/24/2020. The policy indicated, " ...To initiate and maintain a confidential resident centered written plan of care on which each resident's problems, needs, preferences and concerns are addressed to demonstrate that the plans of care of all services are integrated in order to meet the needs of the resident ...." 3.1-35(d)(1) 3.1-35(d)(2)(A)			

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to prevent the development of a pressure ulcer from a medical device for 1 of 3 residents reviewed for pressure ulcers. (Resident 20) Finding includes: During an interview with Resident 20 on 12/18/2023 at 11:13 A.M., he indicated he had a sore on his left leg. He was supposed to wear an orthotic device, and the device had caused the problem. He indicated the strap was too tight and caused the issue. A record review was completed on 12/20/2023 at 9:14 A.M. Diagnoses included, but were not limited to: peripheral vascular disease, left foot drop, and venous insufficiency. A Physician's Order, dated 9/30/2022, indicated to apply splint/brace daily in the morning, and was only allowed on for 2-3 hours a day.	F 0686	1. Resident 20 had the potential to be affected by this alleged deficient practice; however, was not affected. Resident 20 stage 2 pressure area was healed on 9/19/2023. The brace for resident 20 has been on hold starting on 8/29/23. Bionic has adjusted brace, resident unable to wear currently due to health issues. When Resident 20 has orders to start the leg brace back, a check skin for areas due to medical device will be implemented. 2. An audit was conducted to identify any resident with medical devices. There were 11 residents identified who had a medical device, including urinary drainage bags, oxygen tubing, splints/braces, CPAP device and head gear if applied to extremities.	01/15/2024

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	A Quarterly Minimum Data Set (MDS) assessment, dated 8/8/2023, indicated Resident 20 was cognitively intact, and was dependent with lower body dressing and required substantial/maximal assistance with transfer and bed mobility. Resident 20 had no pressure ulcers. A Braden Scale (pressure ulcer risk assessment) was completed on 8/8/2023. The assessment indicated Resident 20 was at mild risk for development of a pressure ulcer. A Weekly Head to Toe Skin Assessment, dated 8/29/2023, indicated Resident 20 had no new skin issues besides those identified, which had not included the pressure ulcer to the left outer leg. A Nurse's Note, dated 8/30/2023 at 9:23 A.M., indicated Resident 20 had complaints that the leg brace was not fitting correctly, and had an area of pressure to the left outer leg. New orders were received to not wear the brace and an associate from the prosthetic company would be at the facility on September 14. A Restorative Care Note, dated 8/30/2023 at 4:52 P.M., indicated, " ..."will discontinue ambulation restorative program at this time r/t [related to] resident having pressure ulcer from shoe brace, required to use to safely ambulate. Brace sent in for adjustments. Resident unable to safely walk with [without] shoe braces ...." A New Ulcer Investigation, dated 8/31/2023 at 2:43 P.M., indicated a stage 2 pressure ulcer, measuring 2.5 centimeters by 3.5 centimeters, was identified. A predisposing factor included immobility, and the brace for the left leg. The probable cause was the medical device. The brace		Nursing orders on the TAR have been reviewed and updated to reflect to check skin under medical devices (See Exhibit 14). 3. Nurses have been in-serviced on pressure ulcer prevention, i.e. risk factors, precautions, and interventions, and checking skin under medical devices on 1-9, 1-10 & 1-11 (See Exhibit 6). All Nurses must be in-serviced, prior to working. 4. All residents with a medical device will be audited weekly. When an order is written for the medical device, an automatic order will be written to check the medical device. On the Unit Manager Weekly Report, if an order for a medical device is written and no order to check for pressure, it will flag on this report. This will be monitored in our Weekly QA meetings. This will continue to be monitored in our monthly and quarterly QAPI meetings until the committee has determined that substantial compliance has been achieved, at least 6 to 12 months. The plan of correction was reviewed in the Quarterly QAPI meeting on 1-11-23. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers, MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office	

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	was to be held until the prosthetic company could come and assess. A Nurse's Note, dated 9/14/2023 at 3:28 P.M., indicated personnel from the prosthetic company came to the facility to assess Resident 20's left leg and the brace. They indicated the brace would need to be adjusted and the metal on the side fixed. During an interview on 12/22/2023 at 10:08 P.M., the Director of Nursing indicated the medical record should have had a physician's order to check the medical device for pressure ulcers, and she was unable to find a physician's order. On 12/22/2023 at 11:18 A.M., a policy titled, "Pressure Ulcer-Prevention" was provided by the Director of Nursing as current. The policy indicated, " ...Precautions & Interventions ...If a medical device is in use (i.e., splints, braces, oxygen tubing, c-pap mask, and head gear) a nurse will check and document weekly if any signs of pressure caused by the device< These checks will be identified on the TAR [Treatment Administration Record]. Documentation will be done in the skin/feet folder in [electronic medical record] ...." 3.1-40(a)		Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

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	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store and serve food under sanitary conditions related to open and undated dry goods in 1 of 1 kitchen and touching the eating surface of salad bowls with bare hands in 2 of 2 dining halls observed. This had the potential to affect all 57 residents who resided in the facility and received food from these dietary areas. Findings include: 1. On 12/18/2023 at 9:45 A.M., the following was observed on the initial kitchen tour with the Director of Nursing (DON): a. A spice cart had opened and undated onion powder, paprika, rosemary, and basil. b. In the dry storage room, Chex, Cheerios, Rice Krispies, and Raisin Bran cereals had been opened and transferred into clear covered bins, but did not have an opened-on date.	F 0812	1 1. No residents were affected by the alleged deficient practice of spices/cereal not being labeled and employee thumb on a serving bowl. 2 2. All residents had the potential to be affected by this deficient practice; however, no residents were identified to be affected by the spices/cereal not being labeled. 3 3. (1) All spices and cereal have now been dated (See Exhibit 15). An in-service has been completed with Dietary employees on 1-10 & 1-11 (See Exhibit 16) on the proper labeling of all spices and cereal. No dietary staff will work after 1-11-24 without being in-serviced. (2) All Dietary employees have been in-serviced on how to handle dishes without touching the surface (See Exhibit 16). Activity	01/12/2024

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	During an interview on 12/18/2023 at 9:53 A.M., the DON indicated the spices and cereal were open and didn't have an opened-on date, but the spices and cereal should have been labeled with the opened-on date. 2. On 12/18/2023 at 12:25 P.M., a dining observation of the main dining hall was completed. Activities Assistant (AA) 2 was observed with her thumb over the rim of the bowl and on the eating surface of 4 out of 4 salad bowls that were served to residents. On 12/21/2023 at 12:01 P.M., a dining observation of the west dining hall was completed. AA 2 was observed with her thumb over the rim of the bowl and on the eating surface of 4 out of 4 salad bowls that were served to residents. During an interview, on 12/21/2023 at 12:06 P.M., AA 2 indicated she had touched the inside of the resident's salad bowl and that she shouldn't have touched the salad bowl's eating surface. On 12/19/2023 at 11:30 A.M., the DON provided a policy, dated 8/1/2022 and titled, "Dietary Stock Procedure", and indicated it was the policy currently used by the facility. The policy indicated, "...5. All food needs to have open dates on them once opened...." On 12/22/2023 at 9:45 A.M., the DON provided a policy, dated 10/26/2012 and titled, "Pre-Meal Dining", and indicated it was the policy currently used by the facility. The policy indicated, "...Lunch Pre-Meal... 3. Do not touch inside of soup bowls, eating surface of soup spoon or eating surface of salad plate when serving resident food item of choice...."		and Nursing personnel have been in-serviced on 1-9, 1-10 and 1-11-24 on proper handling of dishes without touching the surface (See Exhibit 6). Activity employee #2 received a one on one in-service by the Activity Director (See Exhibit 17) No activity or nursing staff will work after 1-11-24 without being in-serviced. 4. (1) Dietary Manager or designee will audit the stock room after stock has been delivered and put away to ensure that all spices and cereal are labeled and dated correctly (See Exhibit 18). This audit will be reviewed in our Weekly, Monthly and Quarterly QAPI meetings until the committee has determined that substantial compliance has been achieved, at least 6 to 12 months (See Exhibit 10 & 13). The plan of correction was reviewed in the Quarterly QAPI meeting on 1-11-23. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers, MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. (2) Infection Control Nurse will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PILGRIM MANOR	222 PARKVIEW ST PLYMOUTH, IN 46563

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	3.1-21(i)(3)		audit meal service for proper handling of dishes and glassware. There will be audits 2 days per week (See Exhibit 19). The audits will be reviewed in our Weekly, Monthly and Quarterly QAPI meetings until the committee has determined that substantial compliance has been achieved, at least 6 to 12 months (See Exhibit 10 & 13).	