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	01/03/2025

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/27/2024. This visit included a PSR to the Investigation of Complaint IN00442061 and Complaint IN00447285 completed on 11/27/2024. Complaint IN00442061 - Not Corrected. Complaint IN00447285 - Corrected Survey dates: 1/2/2025 Facility number: 000030 Provider number: 155703 AIM number: 100275260 Census Bed Type: SNF/NF: 66 SNF:5 Total: 71 Census Payor Type: Medicare: 9 Medicaid: 44 Other: 18 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 1/7/2025	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective January 04, 2025, for the annual revisit survey completed January 02, 2025. Pilgrim Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and	F 0755	It is the practice of this facility to	01/04/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Combs MBA HFA	Administrator	01/10/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	interview, the facility failed to ensure narcotics were counted and documented every shift for 2 of 4 narcotic log books reviewed. (100 Hall & 200 Hall) Findings include: 1. A Medication Storage observation of the 100 hall medication cart was completed, on 1/2/205 at 10:52 A.M., with RN 2. The narcotic log book lacked signatures for the following dates/times: - on 12/27/24 for the 7 AM to 3 PM and 11 PM to 7 AM shift count. - on 12/28/24 for the 11 PM to 7 AM shift count. - on 12/29/24 for the 1 PM to 7 AM shift count. - on 12/30/24 for the 7 AM to 3 PM shift count. - on 12/31/24 for the 3 PM to 11 PM shift count. During an interview, on 1/2/2025 at 10:54 A.M., RN 2 indicated the count sheets should have been signed. 2. A medication storage observation of the 200 hall medication cart was completed, on 1/2/2025 at 10:58 A.M., with LPN 3. The narcotic log book lacked signature for the following date/time: -on 1/1/25 for the 7 AM to 3 PM shift count. During an interview, on 1/2/2025 at 11:00 A.M., LPN 3 indicated the narcotic count sheet should have been signed. On 1/2/2025 at 2:23 P.M., the Director of Nursing provided the policy titled," Controlled Medication Storage", dated 5/20/2020, and indicated the policy was the one currently used by the facility. The policy indicated "... 1. Regulations required that the facility have a system to account for the		provide routine and emergency drugs and biologicals to our residents, or obtain them under agreement described in 483.70(f) The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Narcotic logbooks were signed late by nurses who completed those counts but did not sign off. Nurses who did not complete narc sheets as required received disciplinary action and education. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents who are prescribed narcotic medications have the potential to be affected. An audit of all Narcotic Logbooks was conducted and concerns addressed. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policy for Controlled Medication Storage was reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policies on or before 01/04/2025. Any nursing staff who did not receive in-service will be in-serviced prior to working the	

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	receipt, usage, disposition, and reconciliation of all controlled medication(s). The system includes but is not limited to: ...7. At each shift change, a physical inventory of all controlled medication(s), including the emergency supply, is conducted by two (2) licensed nurses and is documented on the controlled medication accountability record per facility procedure...." This deficiency was cited on 11/27/2024. The facility failed to implement a systemic plan of correction to rpevent recurrance. 3.1-25(e)(2) 3.1-25(e)(3)		floor. Performance improvement tools have been developed to monitor Narcotic Logbooks and narc books will be reviewed daily by DON/Designee ongoing to ensure proper completion. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/Designee will complete routine auditing to ensure there are no missing signatures in the narcotic logbook. Auditing will occur daily ongoing. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 01/04/2025.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medication carts were free from loose medications and failed to have medications labeled with resident	F 0761	It is the practice of this facility that Drugs and biologicals used in the facility be labeled and stored in accordance with currently	01/04/2025

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	identifiers during medication storage reviews for 3 of 3 medication carts observed. (300 hall, 400 hall & 100 hall) Findings include: 1. During a medication storage observation, on 1/2/2025 at 10:36 A.M., with LPN 5 on the 300 hall medication cart, the following was observed: a total of 15 loose pills scattered in the drawers in 3 of 3 drawers of the cart. During an interview, on 1/2/2025 at 10:37 A.M., LPN 5 indicated the loose pills should not be in the medication cart. 2. During a medication storage observation, on 1/2/2025 at 10:39 A.M., with RN 4 on the 400 hall medication cart, the following was observed:- a total of 6 loose pills in various drawers. During an interview, on 1/2/2025 at 10:40 A.M., RN 4 indicated the loose pills should not be in the medication cart. 3. During a medication storage observation, on 1/2/2025 at 10:52 A.M., with RN 2 on the 100 hall medication cart, the following was observed: a container of multi vitamins and an opened container of Magnesium tablets with no resident identifiers. During an interview, on 1/2/2025 at 10:53 A.M., RN 2 indicated the medications should have been labeled. On 1/2/2025 at 2:32 P.M., the Director of Nursing provided the policy titled, "Storage of Medications", dated 5/20/2020, and indicated the policy was the one currently used by the facility.		accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: All loose pills were disposed of properly and unlabeled medications were labeled correctly. Two additional carts were ordered from pharmacy to ensure medications are not overcrowded in the carts to prevent the medications being pressed out the back of the card in the drawer. How are other residents having the potential to be affected by the same deficient practice identified and what corrective action(s) will. be taken; All residents have the potential to be affected. DON/Designee audited all medication carts and treatment carts for compliance with no new concerns noted. An audit of all medication carts and treatment carts will be completed every shift daily ongoing. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility policies on Medication Cart Disinfecting and Medication	

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	The policy indicated "... 22. Medication storage areas are to be kept clean... free of clutter...." This deficiency was cited on 11/27/2024. The facility failed to implement a systemic plan of correction to rpevent recurrance 3.1-25(j) . .		Storage were reviewed by the IDT. An in-service was conducted with all facility nurses and QMAs on the policies. Any nurse or QMA's who were not in-serviced will be in-serviced prior to working the floor. A performance improvement tool has been developed to monitor Medication Carts and Treatment Carts to ensure there are no loose pills, expired meds or opened medications without resident identifiers. How the corrective actions will be monitored to ensure the deficient practice does not recur; The DON/designee will complete routine auditing to ensure Medication Carts and Treatment Carts are free from undated, unlabeled and loose medications. Auditing to occur: Carts will be audited daily shift to shift ongoing. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly, and duration of reviews will be increased as needed if any areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will be completed: 01/04/2025.	

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