STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155073	A. BUILDING -- B. WING	01/02/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/02/25 Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260 At this Emergency Preparedness survey, Pilgrim Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 78 certified beds. At the time of the survey, the census was 71. Quality Review completed on 01/06/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/02/25 Facility Number: 000030 Provider Number: 155073 AIM Number: 100275260 At this Life Safety Code survey, Pilgrim Manor was found not in compliance with Requirements	K 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 10, 2025, for the annual survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Combs MBA HFA	Administrator	01/09/2025

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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	for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. Building 1 is a one-story original constructed facility determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has 78 certified beds. The facility had a census of 71 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for three detached buildings which are a maintenance building, a freezer and the laundry for the facility. Quality Review completed on 01/06/25		completed January 2, 2025. Pilgrim Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer	K 0324	It is the practice of this facility to adhere to all standards defined by NFPA 96, including those specified in K 324. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Caution tape was added outlining the proper location of the stove by the Maintenance Director on	01/10/2025

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	or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff. The findings include: Based on observation and interview during tour of the facility with the Maintenance Director and Administrator from 11:17 a.m. to 12:46 p.m. on 01/02/25, cooking appliances including a gas 6 burner stove with an oven and a flat-top grill located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Maintenance Director and Administrator they were not aware of any method or procedure in place. This finding was reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		1/6/2025. 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 had the potential to be affected, but none were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator and Maintenance Director reviewed the tag cited and decided on the plan to fix the deficiency on January 2, 2025 after the exit conference. Maintenance Director made correction on 1/6/2025 (see attachment Kitchen-K324). An audit was conducted on 1/06/20025 by the Maintenance Director and no other issues were identified (see attachment kitchen audit). An audit tool has been created to ensure that deficient practice is not repeated. How the corrective actions will be monitored to ensure the deficient practice does not recur; The Maintenance Director/designee will complete routine auditing to ensure all cooking appliances are located in the approved area underneath the hood extinguishing system. Auditing to occur: monthly x 6	

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			months. 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: 1/10/2025.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms	K 0511	It is the practice of this facility to adhere to all standards defined by NFPA 54 and NFPA 70, including those specified in K 511. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: Electrical receptacle # 1 found in the Beaty Shop was repaired with the correct Polarity on 1/06/2025 by Maintenance Director (see attached GFCI – K511). Electrical receptacle # 2 located in the Pantry/Linen Room on North Hall was replaced by Maintenance Director on 1/06/2025. How are other residents having the	01/10/2025

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	(2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all		potential to be affected by the same deficient practice identified and what corrective action(s) will be taken; All residents had the potential to be affected, but none were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator and Maintenance Director reviewed the tag cited and decided on the plan to fix the deficiency on January 2, 2025 after the exit conference. Maintenance Director made corrections on 1/6/2025 (see attachment (GFCI – K511). An facility audit was conducted by the maintenance director on 1/06/2025 of all electrical receptacles located within 6 feet of a water sources with no issues noted (see attachment receptacles audit). An audit tool has been created to ensure that deficient practice is not repeated. How the corrective actions will be monitored to ensure the deficient practice does not recur; The Maintenance Director/designee will complete routine auditing to ensure all electrical receptacles within 6 feet of a water sources have a working GFCI outlet. Auditing to occur: monthly x 6 months. In the event any further concerns are identified	

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	receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director and Administrator from 11:17 a.m. to 12:46 p.m. on 01/02/25, 1.) one electric receptacle with a ground fault circuit interrupter (GFCI) 22 inches from a sink in the Beauty Salon failed to function properly when tested. The GFCI tester indicated "Hot/Neutral Reversed" and would not trip when tested multiple times. 2.) one standard electric receptacle 54 inches from a sink was not provided with a ground fault circuit interrupter (GFCI) in the Pantry/Linen room in the North Hall. Based on interview at the time of observation the Maintenance Director acknowledged the electrical receptacles failed to be protected by a ground-fault circuit interrupter and that the tester indicated the Hot and Neutral were reversed according to the GFCI tester. This finding was reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		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: 1/10/2025.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility	K 0761	It is the practice of this facility to	01/10/2025

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	failed to ensure annual inspection and testing of 2 of 2 oxygen storage room fire door assemblies were completed in accordance with LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the		adhere to all standards defined by NFPA 80, including those specified in K 761. The corrective action(s) accomplished for the resident found to have been affected by the deficient practice: The two oxygen storage rooms that were not previously inspected were inspected on 1/06/2025 and documentation created. (see attachment oxygen door inspection – K761) 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 had the potential to be affected, but none were identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator and Maintenance Director reviewed the tag cited and decided on the plan to fix the deficiency on January 2, 2025 after the exit conference. Maintenance Director made corrections on 1/6/2025 (see attachment oxygen door inspection – K761). A facility wide audit was conducted on 1/06/2025 by maintenance director of all doors with swing door assemblies	

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	door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director and Administrator from 11:17 a.m. to 12:46 p.m. on 01/02/25, the facility provided swinging door assembly inspections; however, the documentation failed to include inspections of 2 oxygen storage rooms. Based on interview at the time of record review and interview, the Maintenance Director stated he "Did not know that." This finding was reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		with no issues noted (see attachment swing door assembly audit). An audit tool has been created to ensure that deficient practice is not repeated. How the corrective actions will be monitored to ensure the deficient practice does not recur; The Maintenance Director/designee will complete routine auditing to ensure all swing door assemblies are inspected at least annually. Auditing to occur: monthly x 6 months. 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: 1/10/2025.	