	T OF HEALTH AND HU R MEDICARE & MEDIO						APPROVED O. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE C	ONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		PRIC	00	COMPLETE	D
		155073	A. BUII			10/22/20	14
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			ARKVIEW ST		
PILGRI	/I MANOR				DUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE CO	OMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
000000							
	This visit was f	or a Recertification and	F00	0000	Please accept the attached p	lan	
	State Licensure				of correction as credible		
		Survey			allegation of compliance to th	e	
	Survey Detec: (Databar 15 16 17 20 21			deficiencies cited during our		
		October 15, 16, 17, 20, 21			Annual Health Survey conduction on October 22, 2014. I would		
	and 22, 2014				to formally request your		
		000020			consideration for granting this	;	
	Facility Numbe				facility paper compliance.		
	Provider Numb				Hopefully, you will find the		
	AIM Number:	100275260			remedies are sufficient, thoroughly explained and able	a to	
					provide a clear picture of how		
	Survey Team:				corrected these concerns. Th		
	Debora Kamme	•			Medical Director has been		
	Julie Wagoner,				consulted and has agreed wit	h	
	Lora Swanson,	RN			the plan of correction as submitted. If after reviewing of	our	
	Sharon Ewing,	RN			plan of correction you have a		
	(October 15 & 2	20, 2014)			questions or require additiona information, please do not		
	Census Bed Ty	ne			hesitate to contact Lori Smith	,	
	SNF: 6				Administrator at 574-936-994	3.	
	SNF/NF: 51				Thank you.		
	Total: 57						
	10(a). 57						
	Census Payor T	vpe:					
	Medicare: 8						
	Medicaid: 35						
	Other: 14						
	Total: 57						
	10001.07						
	These deficience	eies reflect state findings					
		ince with 410 IAC					
	16.2-3.1.	-					
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	8	TITLE	(X	6) DATE

PRINTED:

11/19/2014

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	(X2) MULTIPLE C A. BUILDING B. WING	00		: survey leted 2/2014
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	_	
	1 MANOR			ARKVIEW ST DUTH, IN 46563		
						1
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
		completed on October enda Meredith, R.N.				
=000226 SS=D	ETC POLICIES The facility must written policies and mistreatment, new residents and mist property. Based on record the facility faile policy regarding for an allegation followed for 1 of investigations re- investigation in Findings includ During an inter- oriented Reside 10/16/14 at 11:2 indicated a nurs "verbally abuse had reported the Administrator a issue to the "Sta further regardin	volved Resident #8. ed: view, with alert and nt #8, conducted on 20 A.M., the resident ing assistant had d" him. He indicated he	F000226	1. Resident #8 was not aff by this alleged deficient pra 2. All residents have the pr to be affected by this allege deficient practice. The "Ab Prevention Policy & Proced has been updated (See Exhibit 1). According to the of allegation, severity, time of when it was reported and contributing factors, there r interviews conducted with s cognitively alert residents, f members, visitors, etc. The investigation will gather information to determine th cause to allow changes to made to protect all resident The "Abuse Prevention Pol Procedure" has been upda (See Exhibit 1). According type of allegation, severity, frame of when it was report and other contributing factor there may be interviews	e root be to the ticy & to the to the ticy & ted to the time ted	11/20/201

Event ID:

7R2S11

Facility ID: 000030

If continuation sheet Page 2 of 31

	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	I OF CORRECTION	IDENTIFICATION NUMBER: 155073	A. BUILDING B. WING	00	COMPLETED 10/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
PILGRIN	M MANOR			ARKVIEW ST DUTH, IN 46563		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC	
TAG	but could not be had been abusiv verbalizations. A review of an conducted on 14 12:30 P.M. The involving Resid indicated on 07, reported to the 1 Nursing) that C abused him with tone"during the allegation was n Department of 1 entities on 07/2 which was initia completed on 0 and Resident #8 regarding his ca The facility's in documentation Resident #8 and CNA #2 regard facility conclud followed their p escalating situa- in-serviced again policies and she any care assignt	Abuse Investigation was 0/17/14 at 12:15 P.M e allegation of abuse lent #8 and CNA #2, /28/14, Resident #8 DON (Director of NA #2 had verbally h her "attitude and previous week. The reported to the Health and other required 8/14. The investigation, ated on 07/28/14 and 7/29/14 indicated CNA #2 8 had a verbal altercation are requests on 07/25/14. vestigation included of an interview with 4 a statement written by ing the altercation. The ed CNA #2 had not policy related to handling tions and she was in on two of the related e was also removed from ment for Resident #8. other interviews the investigative	TAG	DEFICIENCY) conducted with staff, cognitive alert residents, family member visitors, etc. The investigation gather information to determin the root cause to allow change to be made to protect all residents. The Administrator and/or Director of nursing will conduct most investigations. Nurses will be in-serviced on 11-12-14 through 11-14-14 on investigation process. Examples: *A cognitively impaired resident makes phys contact with another cognitive impaired resident in the hall at was witnessed by 2 staff members. Both staff member would be interviewed. *Allegat of an employee raising their voice at a resident in the dinin room. Staff, families and other cognitively alert residents, that were present, may be interviewed. *Resident alleged Aide was rough when assistin her to bed. Staff in the vicinity when it occurred, anyone in the room at the time and other cognitively alert residents (randomly selected), that the accused employee has worke with, would be interviewed. 4. Monthly, all reportable incident regards to abuse, will be reviet at the Monthly QA Committee meeting (See Exhibit 2). Thes meetings are attended by: Administrator, Director of Nursing, Unit Managers (2), M Coordinator, Staff Developme Coordinator, Business Office	d d d d d barre d d c tts in wwed se 1DS	

Event ID: 7

7R2S11 Facility

Facility ID: 000030

If continuation sheet Page

PRETX TAG CEACH DEFICENCY MUST BE PRUCEDED BY FULL RECULTION OF CLSC IDENTIFYING INFORMATION An interview with the DON, on 10/21/2014 at 10:45 A.M., indicated she did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only involved one resident and one employce. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often in requests particular staff not care for him and the later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. PRETX TAG PRETX TAG COMPLET Manager and Environmental Services Director. The Monthly OA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns. COMPLET DATE An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #A and CNA #2, the Administrator indicated it was part of an In the section administrator indicated it was part of an	STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
1455073 B. WING 10/22/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 222 PARKVIEW ST PILCRIM MANOR 222 PARKVIEW ST PLYMOUTH, IN 46563 D YM SUMMARY STATEMENT OF DEFICIENCIES PRETX CACIL DIPCIENCY MIST IN PRECEDD IN FULL YM REGIL ATORY OR EXCIDENTIFYING INFORMATION An interview with the DON, on 10/21/2014 at 10.45 A.M., indicated she did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only Director, Dietary Manager and monitoring of this tag, He attends Environmental Services Director, Dietary Manager and Environmental Services Director, Obertary Manager and Environmental Services Director, Dietary Manager and Environmental Services Director, Dietary Manager and Environmental Services Director, Obertary Manager and Environmental Services Orther duration and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and the investigation was was completed on 07/28/14 and the investigation He attends was completed on 07/28/14 and the investigation Was has a lal	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		I DING	00	CON	APLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PILCRIM MANOR Z22 PARKVIEW ST PLICRIM MANOR D CM1D SUMMARY STATEMENT OF DEFICIENCIES PREFIX CACID DEFICIENCY MUST BE PRECEDED BY PLLI. TAG REGULATORY OR LODINITY/INCROMMATION An interview with the DON, on 10/21/2014 at 10:45 A.M., indicated she did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only Involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was Completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later receants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/28/14 and the investigation was an opportunity to ask questions and voice concerns. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely			155073				10/	22/2014
NAME OF PROVIDER OF SUPPLIE 222 PARKVIEW ST PILGRIM MANOR 222 PARKVIEW ST PILGRIM MANOR 222 PARKVIEW ST VAH D SUMMARY STATEMENT OF DEFICIENCIES D TAG RECULATORY OR LSC IDENTITYING INTOKANTON) TAG PREFIX COMPLET TAG Interview with the DON, on No Manager, Social Service Director, Medical Records, Activity Director. #8 and CNA #2 because the incident only involved one resident and one employce. CNA #2, was not scheduled to work on O7/28/14 and did not work on 07/29/14 Manager, Social Service Director, Medical Director Medical Records, Activity Director. The Medical Director, Medical Director, Medical Director, Medical Records, Activity Director. The Medical Director Will receive copies of the Monthity QA meetings that addresses the monitoring of this tag. He athends the quarterly QA meetings and addresses the monitoring of this tag. He athends the quarterly QA meetings and adverses the monitoring of this tag. He athends the quarterly OA meetings and adverses the monitoring of this tag. He athends the accused CNA (CNA #2) did receive other education and it was filt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator discuss and interview and complete investigation together. In regards to the				D. WI		ADDRESS, CITY, STATE, ZIP CO	DE	
PILGRIM MANOR PLYMOUTH, IN 46563 (20) ID SUMMARY STATEMENT OF DEFICIENCIES REETX ID	NAME OF	PROVIDER OR SUPPLIE	R					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULTION OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPLET TAG An interview with the DON, on 10/21/2014 at 10:45 A.M., indicated she did not interview any other staff members regarding the incident only involved one resident and one employce. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often irrequests particular staff not care for him and the later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 atter re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator indicated the; In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated ite; In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated ite; In regards to the allegation between In tegards to the allegation between Resident #8 and CNA #2, the Administrator indicated ite; The the two and complete investigation to the staff the two and complete investigation to the tween Resident #8 and CNA #2, the In tegards to the allegation between Resident #8 and CNA #2, the In tegards to the allegation between	PILGRIN	I MANOR						
PREFIX CRACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CALL DEFICIENCY MUST BE PRECEDED BY FULL COMPLET TAG BECLIATORY OR ISC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE An interview with the DON, on 10/21/2014 at 10:45 A.M., indicated she Manager, Social Service Director, Medical Records, Activity Directory Directory, Dietary Manager and #8 and CNA #2 because the incident only involved one resident and one employce. Manager, Social Services Director, Will receive copies of the Monthly OA meetings that addresses the 07/28/14 and did not work on 07/29/14 until all of the re-ducation was and ways has an opportunity to ask education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and the inter tecants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education si reported, the remployce is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator indicated the Resident #A add CNA #2, the Administrator indicated it was part of an	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	DROWIDEDIC DI AN OF CODDE	CTION	(X5)
An interview with the DON, on 10/21/2014 at 10:45 A.M., indicated she did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and the investigation was completed on 07/29/14 at 07/29/14 at 07/29/14 at 07/29/14 at 07/29/14 at 07/29/14 after re-education was the allegation was made on 07/28/14 and the investigation was completed to 07/29/14 after re-education was put in place.Manager, Social Service Director, Medical Records, Activity Director. Dietary Manager and Environmental Services Director The Medical Director will receive copies of the Monthly OA meetings that addresses the monitoring of this tag. He attends the quarterly OA meetings and always has an opportunity to ask questions and voice concerns.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between Resident #A and CNA #2, the Administrator indicated it was part of an	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE PROPRIATE	COMPLETIC
10/21/2014 at 10:45 A.M., indicated she did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the accused cna nd it was felt this was a "personality difference" between the two of them. The DON indicated the accused on 07/28/14 and the investigation was completed on 07/28/14 after re-education was put in place.Medical Records, Activity Director, The Medical Director will receive copies of the Monthly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and volce concerns.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation together.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation together.Hedical Records, Activity Director, The Medical Director will investigation its in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation between Resident #8 and CNA #2, the Administrator indicated it was part of an	TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
 ID21/2014 at 10:45 A.M., indicated the did not interview any other staff members regarding the incident between Resident #8 and CNA #2 because the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation between Resident #8 and CNA #2, the Administrator indicated it was part of an 		An interview w	ith the DON, on			-		
did not interview any other stall members regarding the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/29/14 after re-education was put in place.Environmental Services Director. The Medical Director will receive copies of the Monthly GA meetings and 		10/21/2014 at 1	0:45 A.M., indicated she				•	
regarding the incident between Resident #8 and CNA #2 because the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and tid not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was falt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff" not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place.Lithout addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employce is suspended if scheduled to work while investigation together.An interview and complete investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of anIn the allegation for an and was part of an		did not intervie	w any other staff members				er and	
#8 and CNA #2 because the incident only involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/29/14 after re-education was put in place.will receive copies of the Monthly QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employce is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an							Director	
Involved one resident and one employee. CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place.QA meetings that addresses the monitoring of this tag. He attends the quarterly QA meetings and always has an opportunity to ask questions and voice concerns.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation between Resident #8 and CNA #2, the Administrator indicated it was part of anImage: CA CA meetings that addresses the monitoring of this tag.								
CNA #2, was not scheduled to work on 07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation between Resident #8 and CNA #2, the Administrator indicated it was part of an			•				•	
07/28/14 and did not work on 07/29/14 until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/29/14 after re-education was put in place.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
until all of the re-education was completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation 							•	
completed. The DON indicated the accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
accused CNA (CNA #2) did receive other education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
education and it was felt this was a "personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an		-						
"personality difference" between the two of them. The DON indicated the Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation to gether. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an			,					
of them. The DON indicated theResident often requests particular staffnot care for him and then later recantsand wants them back. The allegation wasmade on 07/28/14 and the investigationwas completed on 07/29/14 afterre-education was put in place.An interview with the Administrator, on10/22/2014 at 9:58 A.M., indicated oncean abuse situation is reported, theemployee is suspended if scheduled towork while investigation is in progress,allegation reported timely, DON andAdministrator discuss and interview andcomplete investigation together.In regards to the allegation betweenResident #8 and CNA #2, theAdministrator indicated it was part of an								
Resident often requests particular staff not care for him and then later recants and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
not care for him and then later recantsand wants them back. The allegation wasmade on 07/28/14 and the investigationwas completed on 07/29/14 afterre-education was put in place.An interview with the Administrator, on10/22/2014 at 9:58 A.M., indicated oncean abuse situation is reported, theemployee is suspended if scheduled towork while investigation is in progress,allegation reported timely, DON andAdministrator discuss and interview andcomplete investigation together.In regards to the allegation betweenResident #8 and CNA #2, theAdministrator indicated it was part of an								
and wants them back. The allegation was made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an		Resident often i	equests particular staff					
made on 07/28/14 and the investigation was completed on 07/29/14 after re-education was put in place.An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an		not care for him	and then later recants					
 was completed on 07/29/14 after re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an 		and wants them	back. The allegation was					
re-education was put in place. An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an		made on 07/28/	14 and the investigation					
An interview with the Administrator, on 10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an		was completed	on 07/29/14 after					
10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an		re-education wa	as put in place.					
10/22/2014 at 9:58 A.M., indicated once an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together.In regards to the allegation between 		An interview w	ith the Administrator, on					
an abuse situation is reported, the employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
 employee is suspended if scheduled to work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an			-					
 work while investigation is in progress, allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an 			-					
allegation reported timely, DON and Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an			-					
Administrator discuss and interview and complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
complete investigation together. In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an			-					
In regards to the allegation between Resident #8 and CNA #2, the Administrator indicated it was part of an								
Resident #8 and CNA #2, the Administrator indicated it was part of an			igation together.					
Resident #8 and CNA #2, the Administrator indicated it was part of an		In regards to the	e allegation between					
Administrator indicated it was part of an		-	-					
j ongoing personanty connict between the			ality conflict between the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG two individuals. Other staff were not interviewed because it was considered to be a 1 on 1 issue and more of a personality conflict. The CNA in question has never had any other complaints but did have a history of issues with this resident. The Ombudsman had even been in to try to do conflict resolution between the resident and this aide in the past. The aide would ask the resident to say "please" when he demanded things and this would upset the resident who insisted he did not have to say please. Review of the facility's policy and procedure, titled, Abuse Prevention Policy and Procedure, dated 04/15/11, and indicated as current by the DON, included the following procedures: "...V. Once an allegation has been made, the Director of Nursing or the Administrator will interview the resident and all staff members scheduled with the accused. Documentation will be kept of these interviews " 3.1-28(a) F000248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF SS=D EACH RES FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7R2S11 Facility ID: 000030 If continuation sheet Page 5 of 31

PRINTED:

PRINTED: 11/19/2014 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	(X2) MULTIPLE C A. BUILDING B. WING	00	СОМР 10/22	
	provider or supplie 1 MANOR	R	222 PA	ADDRESS, CITY, STATE, ZIP CODE ARKVIEW ST DUTH, IN 46563		
X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF	E	(X5) COMPLETION
TAG	The facility must program of activit accordance with a assessment, the mental, and psyc resident. Based on observe interviews, the fa activities were p for 1 of 3 reside activities. (Resident Finding include Resident #74 wa from 9:00 A.M. P.M 3:00 P.M her recliner. Sh portions of the t on. Resident #74 wa 10/17/2014 at 2 recliner beside fa Resident #74 wa 10/17/2014 at 2 seated in her rec search book. Sh already read the folded on her be Bingo activity, w	s: as observed, on 10/16/14 - 12:00 P.M. and 1:00 , seated in her room in e was awake for large ime but did doze off and as observed, on :03 P.M., sitting in a her bed.	тад F000248	1. Resident #74's care plan Exhibit 3) and interests (See Exhibit 4) have been reviewed with her and have been upda Activities will have reports m that identifies Resident #74's interest in each type of activ (See Exhibit 5). Prior to an activity, Activities will print the report and if Resident 74 is identified to be interested in activity, she will be asked if s would like to attend. If she declines, attends, was sleep etc. will be documented in the Electronic Chart System (EC (See Exhibit 6). 2. All reside have the potential to be affect by this alleged deficient prace Each resident's interest will a reviewed and their interests be updated in ECS by 11-14 3. Activites will have a report made that identifies each resident's interest in each ty activity (See Exhibit 5). Prior activity, Activities will print the report and attempt to invite e resident that is identified to the interested in that activity. If the resident declines, was sleep attended, etc. will be docum in ECS (See Exhibit 6). A policy/procedure has been developed "Activity Attendar	(See ed ated . ade sity e that she ing, ie SS) ents cted ctice. be will -14. rt pe of to an e each be he ing, ented	DATE

7R2S11

If continuation sheet Page 6 of 31

STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER: 155073	A. BUILDING B. WING	00	COMPLETED 10/22/2014	
NAME OF	PROVIDER OR SUPPLIE	R	STREET	TADDRESS, CITY, STATE, ZIP CODE		
	TROVIDER OR BOTTER			ARKVIEW ST		
PILGRI	M MANOR		PLYM	OUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		e had invited her to go to		residents to activities and documenting attendance of the	20	
		ursing staff were notified		activity (See Exhibit 7). Each		
	and the resident	t was assisted to the		week a report in ECS will be		
	activity.			that identifies each activity		
				interest and if the resident did		
	Resident #74 w	as observed, on		attend the activity that reflects		
		0:48 A.M., sitting in her		their interests, it will flag on th	ne	
		ner. Her daughter was		report (See Exhibit 8). Activities can then evaluate w	/hv a	
		oom. Resident #74's		resident did not attend and m	•	
	-	ted the resident had been		any adjustments that may be		
	e			needed. A policy/procedure l	has	
		ty over the weekend but		been developed "Activity		
		to the painting activity		Audits/Assessments/Care Pla		
		came and got her and the		(See Exhibit 9), that describe		
	resident could r	not remember when		weekly audits and how they a be reviewed. An in-service wi		
	activities were	scheduled. The resident		held for all Activity Staff on		
	indicated she en	njoyed going to activities.		11-15-14 through 11-18-14.		
				4. The Activity Director will re		
	The facility was	s having an exercise		any residents who have need	led	
	activity in the f	-		to have an activity interest	-114 -	
	5	0:59 A.M., but Resident		revised, due to the weekly au in the weekly QA committee	alts,	
		served to participate in the		meeting. (See Exhibit 10).		
		as noted in her room,		The weekly QA committee		
		cliner beside her bed.		consists of: Administrator,		
	seated in the re	unner beside her bed.		Director of Nursing, MDS		
	T1 C 11.	1 1 1 1 / 1		Coordinator, 2-Unit Managers		
	-	s scheduled to have a		Staff Development Coordinate Social Services Director,	or,	
	5	activity at 1:00 P.M. on		Business Office Manager,		
		:25 P.M. on 10/20/14,		Medical Records, Activity		
	there were three	e residents in the activity		Director, Dietary Manager an	d	
	room who had	their nails painted.		Environmental Services Direc		
	Resident #74 w	as observed in her room,		The Medical Director will rece	eive	
	in her recliner.	asleep. Her nails were not		copies of the Weekly QA		
		een manicured or painted.		meetings that addresses the monitoring of this tag. He atte	ende	
		on 10/20/14 at 1:25 P.M.,		the quarterly QA meetings an		
		was painting nails in the		always has an opportunity to		
		ran Paniting name in the				

Event ID:

7R2S11

Facility ID: 000030

If continuation sheet Page 7 of 31

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		ONSTRUCTION 00		ATE SURVEY MPLETED
		155073	A. BUIL B. WINC			10/22/	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD NRKVIEW ST	Ε	
PILGRIM	1 MANOR				DUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ndicated she had started			questions and voice conc	erns.	
		hails as soon as residents					
	were done eatin	g lunch.					
	The facility was	s having exercises in the					
	front lounge on	10/21/2014 at 11:06					
	A.M. There we	ere at least 10 residents					
	present. Reside	ent #74 was sitting in her					
	-	liner awake. She					
	indicated she w	as not aware of the					
	exercises activi	ty but thought it might be					
		exercises now. She					
	-	ould have gone to					
		orning. She stated she					
		ved craft activities.					
	Resident #74 w	as observed, on					
		:52 A.M., in her room					
		evision was on a music					
		out the volume was on					
		as a cup of coffee on the					
		bed table. Resident #74					
		she was going to do this					
		e seemed unaware of the					
	-	y. She indicated she was					
	-	ald remember how to play					
		ve were talking, the					
		r entered the room for a					
	-	ought the resident some					
		ff were noted to invite the					
	-	cipate in the Yahtzee					
		the pastor entering the					
		The facility's scheduled					
	activities for the	e morning of 10/21/14					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG were: coffee scheduled for 8:15 A.M. and Yahtzee at 10:00 A.M. There were three residents and two staff members noted in the activity room talking and drinking coffee at 10:05 A.M. The three residents and CNA #1 were then noted to play Yahtzee around 10:20 A.M. There was a "Scrap" craft activity scheduled on 10/21/14 at 1:00 P.M. Resident #74 did not attend the activity. The clinical record for Resident #74 was reviewed on 10/17/2014 at 12:14 P.M. Resident #74 was admitted to the facility on 08/22/14 with diagnosis, including but not limited to: aortic valve disorder, congestive heart failure, coronary artery disease, hypertension, dementia, anxiety, and end stage aortic valve disorder. Activity notes, dated 08/26/14, indicated the resident was very friendly and enjoyed reading in her room. The resident was looking forward to pet visits and enjoyed group activities and going outside. She also was a member of a church in the past. The activity attendance records from 10/10/14 - 10/17/14 indicated the resident had attended exercises, a craft activity, and Bingo on 10/10/14 but had only attended the soup serving just prior to the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7R2S11 Facility ID: 000030 If continuation sheet Page 9 of 31

PRINTED:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) I	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI	JILDING	00	C	OMPLETED
		155073	A. BU B. W			- 1	0/22/2014
NAME OF					ADDRESS, CITY, STATE, ZIP (CODE	
NAME OF	PROVIDER OR SUPPLIE	.K		222 PA	RKVIEW ST		
PILGRI	/I MANOR			PLYMO	DUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		her newspaper in her					
		ved a beverage in her					
	room from the o	drink cart on a daily basis.					
	The care plan re	elated to activities,					
	-	03/14, for Resident #74					
	indicated the re						
		group activities and did					
		tivities in her room. The					
	_	e resident to be involved					
	-	activities, group activities					
		lependent activities 2 - 3					
	-	The interventions included					
	encourage activ	vity participation, assist to					
	activities as nee	eded, and assess interests					
	and strengths an	nd provide and review the					
	activity calenda	r with the resident.					
	During an inter	view, on 10/22/2014 at					
	9:30 A.M., The	Activity Director					
		sident did not attend the					
	craft activity or	10/21/14 in the					
		indicated when the					
		vited to an activity $1/2$					
	-	e activity she sometimes					
	-	attending the activity. The					
	-	r was unsure if it was a					
		veen activity staff and					
	-	who would have to switch					
		kygen in order for the					
		ble to attend the activity					
		ed and brought the					
		scheduled activity. There					
	was no reason g	given as to why the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG resident did not attend the craft activity. The Activity Director thought perhaps the resident was also forgetting the invitation to the activity and perhaps the activity assistant was not actually going back to to ensure the resident was assisted to many of the scheduled activities. 3.1-33(a) F000257 483.15(h)(6) **COMFORTABLE & SAFE TEMPERATURE** SS=D LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F Based on observation and interviews, the F000257 1. Resident #14 was affected by 11/20/2014 this alleged deficient practice facility failed to ensure a room because she feels the room is too temperature was within the acceptable hot. Her roommate has agreed to parameters. This had the potential to keep the shade, in the shared room, closed during the day when affect 1 of 26 residents residing on the the sun is out. Both residents East hallway. (Resident #13) have agreed to open the window, as needed, to keep the room Finding includes: temperature anywhere from 71 to 81 degrees. 2. No other residents have been affected by On 10/16/14 at 12:52 P.M., an interview this alleged deficient practice. 3. with Resident #13 indicated her room During the season when the was always hot causing her to run a fan at weather is in transition, both roommates have agreed to have all times to keep cool. the shade pulled during the time the sun is out. They have both On 10/16/14 at 12:55 P.M., Resident #13 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7R2S11 Facility ID: 000030 If continuation sheet Page 11 of 31

PRINTED:

	T OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED B NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		NNC	00	COMPL	ETED
		155073	A. BUILI B. WING	UNG		10/22/	2014
			B. WING	STREET	ADDRESS, CITY, STATE, ZIP CODE		
AME OF I	PROVIDER OR SUPPLIE	R			RKVIEW ST		
PILGRIM	1 MANOR				DUTH, IN 46563		
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	was observed re	esting in her bed with a			agreed if the temperature rises	s to	
	thin night gown	on and a sheet pulled			above 81 degrees that the		
		a fan was observed at the			window can be slightly opened	l to	
	-	and it was running on the			lower the room temperature		
		and it was fulling on the			between 71-81 degrees. Both residents have been offered th		
	low speed.				opportunity to move rooms;	IC I	
					however, both have declined.		
	On 10/22/14 fro	m 10:30 A.M. to 10:50			The room temperature in		
	A.M., an enviro	nmental tour was			Resident #14's room will be		
	conducted with	the Administrator and the			checked twice daily, during		
		pervisor, during which			seasonal transition (See Exhib	oit	
	the following w				11). This will ensure the room		
	the following w	as observed.			temperature is maintained		
					between 71-81 degrees. Durin	ng	
	East hallway:				the winter months, if the		
					temperatures are remaining stable, temperatures will be ta	kon	
	At 10:45 A.M.,	Resident #13 was			randomly 3x per week. This w		
	observed resting	g in her bed with a thin			be determined by the QA		
		nd a fan running at the			committee. Maintenance will		
		The Maintenance			complete room temperatures		
					during the weekdays and nurs	ing	
	-	ked the air temperature			will complete room		
		meter and the room			temperatures on the weekends		
	-	s 82.3 degrees Fahrenheit			Nursing and Maintenance will		
	at the resident's	bedside. The			in-serviced on 11-12-14 throug	Ju	
	Maintenance Su	pervisor walked across			11-14-14. 4. Weekly the Supervisor of Maintenance wil	I	
	the room to the	window and checked the			present any issues with		
		beside the window and			the temperature findings at the	;	
	-	85.6 degrees Fahrenheit.			Weekly QA meeting (See Exhi		
	-	-			10). The Weekly QA Committe		
		e Supervisor confirmed			consists of: Administrator,		
		base board heat in the			Director of Nursing, MDS		
	room was not ev	ven on.			Coordinator, 2 - Unit Manager		
					Staff Development Coordinato		
	During an interv	view on 10/22/14 at 10:50			Social Service Director, Busine	ess	
		nistrator indicated			Office Manager, Medical	vity	
		roommate liked the room			Records, Dietary Director, Act Director and Environmental	vity	
					Services Director. The Medica	al	
	warmer and refu	used to have the light				~ 1	

Event ID: 7F

7R2S11 Facili

Facility ID: 000030

If continuation sheet Page 12 of 31

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG Director will receive copies of the filtering blinds pulled. The Administrator Weekly QA meetings that further indicated the morning sun shined addresses the monitoring of this in the window and created a lot of heat. It tag. He attends the quarterly QA would have helped if the roommate meetings and always has an would of agreed to close the blinds, but opportunity to ask questions and voice concerns. she refused. 3.1-19(h) F000279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE SS=D PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). 1. Resident #64 was not affected Based on observation, record review and F000279 11/20/2014 by this alleged deficient practice. interview, the facility failed to careplan The individual care plan for this assistive devices used by the resident for resident was updated on FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7R2S11 Facility ID: 000030 If continuation sheet Page 13 of 31

PRINTED:

STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	X3) DATE SURVEY
AND PLAN	N OF CORRECTION	IDENTIFICATION NUMBER: 155073	A. BUILDING B. WING	00	COMPLETED 10/22/2014
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
	M MANOR			ARKVIEW ST OUTH, IN 46563	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		
		aid in the prevention of a		10-21-14. The intervention add reads "know that Resident #64	
		1 of 3 resident's reviewed		up independently and prefers to	
	for accidents. (l	Resident #64)		use wheelchair when out of roo	
				and walker when in her room".	
	Finding include	es:		This information is available for	
				staff on the CNA care plan post	
	The clinical rec	ord of Resident #64 was		behind the head of the bed. (Se Exhibit 12) 2. All residents who	
	reviewed on 10	-20-14 at 9:15 A.M. The		require or choose to use an	0
	resident's diagn	oses included but were		assistive device have the	
	•	lementia, depression,		potential to be affected by this	
		nd hypertonicity of the		alleged deficient practice. All	
	bladder.	ing hypertoinenty of the		residents will have their individu care plans reviewed to ensure	Jal
	oludiel.			their means of mobility and any	,
	$0n 10_20_1/14 at$	9:20 A.M., a review of		assistive devices are included.	
		t Report indicated		This information will be availabl	e
		ell, on 9-26-14 around		for staff on the CNA care plan	
				posted behind the head of the bed. All will be reviewed by	
		le walking to the		11-17-14. 3. All new admission	ns
		bare feet. The report		will have a Fall Risk Assessmer	
		ew interventions		completed within 24 hours of	
	-	e " Education was done		admission. This also will includ	le
	-	of using her walker and		determining the resident's mobility, and the use of any	
		nt for help if needed"		assistive devices. The mobility	
		apparent injuries. The fall		and assistive devices will	
	-	was reviewed the same		automatically write to the	
		R (Fall/Accident		individual residents Fall Care	
		eview) Committee with		Plan. The individual care plan information is available for staff	,
		endations to prevent a fall		on the CNA care plan posted at	
		: further education with		the head of the bed. The Unit	
	the resident abo	out the importance of		Manager will continue to place	
	wearing non-sk	id socks or shoes to		CNA care plans at the head of t	the
	prevent residen	t from slipping. The		bed. Any subsequent Fall Risk Assessments completed; annua	al
	resident was ins	structed to call for help if		quarterly, change of condition,	Ju,
	she felt the floo	or appeared wet or		etc., will include reviewing the	
		use the call light if her		mobility and assistive devices	

cluttered and to use the call light if her

Event ID: 7R2

7R2S11 Facilit

Facility ID: 000030

mobility and assistive devices

If continuation sheet

Page 14 of 31

NTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039			
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED			
		155073	B. WING		10/22/	2014			
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	-				
PILGRIN	1 MANOR			ARKVIEW ST OUTH, IN 46563					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROVIDER'S DI AN OF CORRECTION		(X5)			
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE			
	shoes weren't w	rithin reach. The resident		used, if any. The care plan wi					
	was then given	an opportunity to give		reviewed at that time to ensur	e it				
	-	estions and the resident		is accurate. The "Fall Risk					
		d make sure she had her		Assessment" policy has been					
		eport further indicated		reviewed and updated to inclu these changes (See Exhibit 13					
		-		All nurses will be in-serviced of					
	"Did not chan	ge care plan"		the "Fall Risk Assessment" po					
				on 11-12-14 through 11-14-14	-				
	A review of the	last quarterly fall		4. The Unit Managers will rep	nrough 11-14-14. lanagers will report Weekly QA (See mmittee meeting of assistive devices				
	assessment, dat	ed 9-8-14, indicated the		weekly in the Weekly QA (See					
	resident was at	a high risk for a fall and		Exhibit 10) Committee meetin					
	had a balance p	roblem while walking.		any mobility, assistive devices	6				
	-	nent further indicated the		and care plan discrepencies noted for the Fall Risk					
		d use of an assistive		Assessments reviewed that					
	-	heelchair, walker) but		week. The weekly QA					
	· · ·			Committee consists of:					
	didn't specify w	men one.		Administrator, Director of					
				Nursing, MDS Coordinator, 2	-				
		9:35 A.M., a careplan,		Unit Managers, Staff	oiol				
		nd revised on 9-8-14,		Development Coordinator, So Service Director, Business Of					
		sident was at risk for falls		Manager, Medical Records,					
	related to deme	ntia. The interventions		Dietary Director, Activity Director	tor				
	included: skid-p	proof footwear, pathway		and Environmental Services					
	-	within reach, remind		Director. The Medical Directo					
		for assistance if needed,		will receive copies of the Wee	-				
		d posture, do fall risk		QA meetings that addresses t					
	-	facility protocol, and		monitoring of this tag. He attended the quarterly QA meetings and					
	-			always has an opportunity to a					
	assess need for	salety devices.		questions and voice concerns					
	0. 10 20 14 4	9:45 A.M., the resident							

On 10-20-14 at 9:45 A.M., the resident was observed propelling herself from the activity room in a wheelchair.

On 10-20-14 at 10:15 A.M., the Quarterly MDS (Minimum Data Set) Assessment, dated 9-5-14, indicated the resident used

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7R

7R2S11 Facility ID:

Facility ID: 000030

If continuation sheet

Page 15 of 31

PRINTED:

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	ONSTRUCTION	(X3) D.	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	CO	MPLETED
		155073	A. BU B. WI	ILDING		10/22/2	
			D. W1		ADDRESS, CITY, STATE, ZIP CO	DDE	
NAME OF	PROVIDER OR SUPPLIE	ER			RKVIEW ST	,52	
PILGRI	/ MANOR				OUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH	OULD BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
	mobility device	es such as a wheelchair					
	-	e assessment further					
	indicated the re	sident walked in her room					
		and required no staff help					
	or oversight.						
	During an inter	view, on 10-20-14 at					
	e	NA #11 indicated she was					
		ne resident's interventions					
		alls from occurring.					
	-	ndicated a CNA					
	-	rd/Careplan was located at					
		bed and the interventions					
	would be includ	led on the form.					
	During an inter	view, on 10-20-14 at					
	10:28 A.M., Ur	nit Manager #12 indicated					
	the the resident	uses a wheelchair outside					
	of her room and	a walker to transfer in					
	her room. She	further indicated the					
	resident transfe	rred herself and decided					
		device she would use.					
		2 00 D M					
		3:00 P.M., a review of					
	-	nment Card, located a the					
		Resident #64 indicated					
	-	ise skid-proof footwear,					
		clear, call light within					
	reach and remin	nd resident to ask for					
	assistance if ne	eded. The CNA					
	Assignment Ca	rd did not indicate the					
		use a walker when					
	ambulating in h	er room or a wheelchair					
	-	ng in the hallways. A					
		<i>o</i>			1		1

	R MEDICARE & MEDIC						OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	NSTRUCTION	Č, Ž	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	JILDING	00		IPLETED
		155073	B. W	ING		- 10/2	22/2014
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	ODE	
					RKVIEW ST		
PILGRIM	1 MANOR			PLYMO	UTH, IN 46563		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A		COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		erved to be located near					
		he was sitting in a					
	recliner.						
		view, on 10-21-14 at 1:20					
		indicated all interventions					
	-	should have been on the					
	· ·	ing assistive devices.					
	The DON furthe	er indicated the CNA					
	Assignment Car	d would also have been					
	updated to inclu	de interventions such as					
	assistive devices	s. The DON could not					
	explain why Res	sident # 64's careplan nor					
	CNA Assignme	nt Card did not include					
	the use of a wall	ker or wheelchair with					
	ambulation to p	revent falls.					
	3.1-35(a)						
000280	483.20(d)(3), 483	10/4)(2)					
SS=D							
	CARE-REVISE C						
		the right, unless adjudged					
		herwise found to be					
		ler the laws of the State, to ning care and treatment or					
	changes in care a						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. 1. Resident #67's care plan has Based on observation, record review and F000280 11/20/2014 been updated to reflect her interview, the facility failed to ensure the current status (See Exhibit 14). care plan related to activities for 1 of 3 2. All residents have the potential residents reviewed for activities was to be affected by this alleged deficient practice. A report has updated to reflect her current status. been made for each resident that (Resident #67) will pull the care plan, activity interests and activity Finding includes: assessments (See Exhibit 15). The information in the report will be reviewed and the care plans Resident #67 was observed, on 10/16/17 will be updated, if needed, to from 8:30 A.M. - 12:00 P.M. and 1:00 reflect the resident's current P.M. - 3:00 P.M., to be sleeping in her status. The care plans and bed. She was not observed to participate activity interests will be completed, if needed, by in any scheduled activities. 11-18-14. 3. Each week a report in ECS will be ran that Resident #67 was observed, on 10/17/14identifies each resident's activity from 9:00 A.M. - 11:00 A.M., lying in interest and if the resident did not attend the activity that reflects her bed asleep. their interests, it will flag on the report (See Exhibit 8). Activities Resident #67 was observed, on will then evaluate each flagged 10/17/2014 at 2:39 P.M., lying in her bed resident to monitor if the care plan needs to be changed and asleep. There were several residents make adjustments as needed. A observed in the dining room, across from policy/procedure has been

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7R

7R2S11 Facil

Facility ID: 000030

If continuation sheet

Page 18 of 31

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			onstruction 00	(X3) DATE SURVEY COMPLETED	
		155073	A. BUII B. WIN	G			22/2014
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ARKVIEW ST	Е	
PILGRIN	/ MANOR				DUTH, IN 46563		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	COMPLETIC DATE
IAG		,		IAU	developed "Activity		DATE
	Resident #67 w at 9:00 A.M., ly Resident #67 w 10/20/2014 at 1 herself around t donut. The bea cut and dried re morning. Resident #67 w 10/20/2014 at 1 herself around t facility. She wa doorway to the exercises was b asked "who are not enter the roo activities, but w few minutes fro Resident #67 w 10/20/2014 2:00 wheelchair arou been a previous "Fancy Nails" c room. The resi	0:42 A.M., propelling he facility and eating a utician indicated she had esident's hair earlier in the as observed, on 1:00 A.M., propelling he front hall of the as noted to go into the front lounge where eing conducted and she they watching?" She did om or participate in atched the activity for a m the entryway.			developed "Activity Audits/Assessments/Care (See Exhibit 9), that desc weekly audits and how th be reviewed. An in-servic held for all Activity Staff of 11-15-14 through 11-18-' The Activity Director will r any residents who have r to have a care plan/intere updated to reflect their cu status, due to the weekly (See Exhibit 10). The we committee consists of: Administrator, Director of Nursing, MDS Coordinato Managers, Staff Develop Coordinator, Social Servi Director, Business Office Manager, Medical Record Activity Director, Dietary I and Environmental Servic Director. The Medical Dii will receive copies of the QA meetings that addres monitoring of this tag. He the quarterly QA meeting always has an opportunit questions and voice cond	ribes the ey are to e will be n 14. 4. report needed ests urrent audits. sekly QA or, 2-Unit ment ces ds, Manager ces rector Weekly ses the attends s and y to ask	
	Resident #67 w 10/20/2014 3:08	as observed, on 3 P.M., propelling her					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IULTIPLE CO	DNSTRUCTION 00	CO	ATE SURVEY OMPLETED
		155073	B. WI	NG		- 10)/22/2014
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CO	DE	
					RKVIEW ST		
PILGRIN	/I MANOR			PLYMC	OUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	ULD BE PROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and the facility holding a					
		. The resident was					
		oyed talking briefly about					
	her frog though	she did not stop					
	propelling her v	wheelchair to talk.					
	Resident #67 w	as observed, on					
	10/21/2014 9:54	4 A.M., in her bed asleep.					
	Her roommate	indicated she had slept a					
	lot this morning	g. Staff were heard					
	inviting a few r	esidents to a 10:00					
	Yahtzee activity	у.					
		ord for Resident #67 was					
		/20/14 at 10:10 A.M. The					
		d the resident was					
		16/14 The resident's					
	e e	ded, but were not limited					
		pertension, and					
	depression.						
	An initial activi	ty assessment for					
	Resident #67, c	ompleted on 12/23/13,					
	indicated the re	sident enjoyed visiting					
	with family and	l friends, was a member of					
	the Catholic ch	urch, liked to listen to					
	quiet music and	l instrumental music, liked					
	to watch televis	ion and movies, liked to					
	keep up on the	news, enjoyed social					
		ies, liked watching birds					
	-	als, liked to be outside,					
		e asked to go on outings,					
		crossword puzzles,					
		vord games and play					
	1 * ,		1				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ĩ.	ULTIPLE CC LDING	NSTRUCTION 00	· · ·	TE SURVEY 1PLETED
		155073	B. WING			10/2	22/2014
NAME OF	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
		ι (i α a a a a a a a a a a a a a a a a a a			RKVIEW ST		
PILGRIN	I MANOR			PLYMO	UTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Bingo.						
	A ativity motor	datad 01/11/11 indicated					
	-	dated 01/14/14, indicated					
	· ·	num data set) assessment					
		overall improvement in					
	ADL (activities	The note indicated the					
	1	eerful and enjoyed					
		ople, had frequent family					
		ls and animals, liked to					
	,	usic, occasionally					
		ses and Bingo, read					
		newspapers, watching the					
		ews programs, liked to					
		outside, liked to go on					
	-	rossword puzzles,					
		vord games, and was a					
	member of a Ca						
	A quarterly acti	vity note, dated 04/03/14,					
	indicated the re-	sident came to an activity					
	only occasional	ly, like to wheel herself					
		ity and look at things,					
	-	lot, was not very					
	talkative, could	•					
		vith others, liked to look					
		s in the dining room and					
	-	alarly by her children.					
	-	ly activity note, dated					
		ated the resident was					
	-	ly by her daughter, slept					
		but if she was up enjoyed					
	-	f around the facility, was					
	confused and so	ometimes argumentative,					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	ONSTRUCTION	(X3) I	DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155073	A. BU B. WI	JILDING NG	00	COMPLETED 10/22/2014	
					ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	R		222 PA	RKVIEW ST		
PILGRI	1 MANOR			PLYMC	OUTH, IN 46563		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	would sometim	es join exercises, and					
	would passively	observed activities at					
	times, and liked	l to sit by the window and					
	look outside.						
		ndance record, from					
		0/14, indicated the					
	-	ne to the beauty shop one					
	· ·	ipated in drink cart 5					
	times, had parti	cipated in a pre-meal soup					
	one time, and h	ad participated in a					
	popcorn event of	one time in the past week.					
	The care plan for	or Resident #67, initiated					
	on 12/23/13 and	l current through					
	01/15/15, regar	ding activities, indicated					
	the resident nee	ded encouragement to					
	attend activities	. The interventions					
	included to prov	vide/review the activity					
	-	to activities, inform of					
		e involvement, and invite					
	· 1	daily. The goal was for the					
	e e	volved in group					
		o outings, and out of room					
		2 - 3 times a week.					
	,						
	An interview w	ith the Activity Director,					
		9:00 A.M., indicated the					
		ty involvement had					
		Activity Director					
		esident really did not join					
		anymore. She indicated					
		vas awake, she would					
		round the facility in her					
	wheet herself al	ound the facility in her	1				

NTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-0.
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	(X2) MULTIPLE CO A. BUILDING B. WING	00	x3) date survey completed 10/22/2014
NAME OF	PROVIDER OR SUPPLIEI	3	STREET	ADDRESS, CITY, STATE, ZIP CODE	
	1 MANOR			RKVIEW ST DUTH, IN 46563	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	e (X5) COMPLETI DATE
	observe brief pa passively. She is and pre-meal so the activity assis beverages before beverages in the Director indicate whom visited he of the resident's attendance and p no revised plan	might occasionally rts of an activity ndicated the drink cart up activity consisted of stant serving soup and e the meal and passing afternoons. The Activity ed the resident's daughter, er frequently, was aware decline in activity participation. There was to address activities to tt's current needs.			
000323 3S=D	The facility must e environment rema hazards as is pos receives adequate assistance device Based on record the facility failed devices were cat implemented to	RVISION/DEVICES ensure that the resident ains as free of accident sible; and each resident e supervision and es to prevent accidents. review and interview, d to ensure assistive	F000323	1. Resident #64 was not affecte by this alleged deficient practic The individual care plan for this resident was updated on 10-21-14. The intervention add reads "know that Resident #64 up independently and prefers to use wheelchair when out of roc	e. ed is o

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	DNSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	~ ~		00	COMPI	
		155073	A. BUILDIN B. WING	NG		10/22	/2014
				TREET /	ADDRESS, CITY, STATE, ZIP CODE		
AME OF	PROVIDER OR SUPPLIE	R			RKVIEW ST		
PILGRIM	1 MANOR				OUTH, IN 46563		
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	Т	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
					and walker when in her room"		
	Finding include	s:			This information is available for		
					staff on the CNA care plan po		
	The clinical rec	ord of Resident #64 was			behind the head of the bed. (S		
					Exhibit 12) 2. All residents wh require or choose to use an	10	
		-20-14 at 9:15 A.M. The			assistive device have the		
	-	oses included but were			potential to be affected by this	i	
	not limited to: d	lementia, depression,			alleged deficient practice. All		
	hypertension, an	nd hypertonicity of the			residents will have their individ	dual	
	bladder.				care plans reviewed to ensure	;	
					their means of mobility and an		
	On 10-20-14 at	9:20 A.M., a review of a			assistive devices are included		
					This information will be available		
	-	ort indicated Resident			for staff on the CNA care plan		
	-	6-14 around 8:45 A.M.,			posted behind the head of the bed. All will be reviewed by		
	-	o the bathroom with bare			11-17-14. 3. All new admission	ns	
	feet. The report	indicated the fall was			will have a Fall Risk Assessm	-	
	unwitnessed by	a staff member and the			completed withinn 24 hours of		
	resident reporte	d she slipped on some			admission. This also will inclu		
	water. The resid	dent was educated on the			determining the resident's		
		sing her walker and using			mobility, and the use of any		
	-	elp if needed. There			assistive devices. The mobility	/	
	•	•			and assistive devices will		
		nt injuries. The fall			automatically write to the individual residents Fall Care		
		was reviewed the same			Plan. The individual care plan		
	day, by a FAIR				information is available for sta		
	Interdisciplinary	y Review) Committee,			on the CNA care plan posted		
	with further rec	ommendations to prevent			the head of the bed. The Unit		
		luded: further education			Manager's will continue to play		
		at about the importance of			the CNA care plans at the hea		
		id socks or shoes to			the bed. Any subsequent Fall		
pro	-				Risk Assessments completed		
	-	t from slipping. The			annual, quarterly, change of condition, etc., will include		
		o instructed to call for			reviewing the mobility and		
	help if she felt t	he floor appeared wet or			assistive devices used, if any.		
	cluttered and to	use the call light if her			The care plan will be reviewed		
	shoes weren't w	ithin reach. The resident			that time to ensure it is accura		
		an opportunity to give			The "Fall Risk Assessment"		

Event ID:

7R2S11 Facility ID: 000030

If continuation sheet Page 24 of 31

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/22/2014
NAME OF	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP CODE	10/22/2014
PILGRII	M MANOR			ARKVIEW ST OUTH, IN 46563	
X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	additional sugg indicated she w her shoes on. The indicated the case A review of the assessment, date resident was at had a balance p The fall assessment device (cane, w didn't specify w On 10-20-14 at dated 4-12-13 at indicated the re- related to deme included: skid-p clear, call light resident to ask the monitor gait and assessment per assess need for On 10-20-14 at MDS (Minimum dated 9-5-14, in mobility device and walker. The indicated the re- independently at or oversight. The	estions and the resident ould make sure she had he FAIR Report further replan was not changed. last quarterly fall ed 9-8-14, indicated the a high risk for a fall and roblem while walking. nent further indicated the d use of an assistive heelchair, walker) but thich one. 9:35 A.M., a careplan, nd revised on 9-8-14, sident was at risk for falls ntia. The interventions proof footwear, pathway within reach, remind for assistance if needed, d posture, do fall risk facility protocol, and		policy has been reviewed and updated to include these cham (See Exhibit 13). All nurses wi in-serviced on the "Fall Risk Assessment" policy on 11-12- through 11-14-14. 4. The Unit Managers will report weekly in Weekly QA (See Exhibit 10) Committee meeting of any mobility, assistive devices and care plan descrepencies noted for the Fall Risk Assessments reviewed that week. The week QA Committee consists of: Administrator, Director of Nursing, MDS Coordinator, 2 - Unit Managers, Staff Development Coordinator, So Service Director, Business Off Manager, Medical Records, Dietary Director, Activity Direct and Environmental Services Director. The Medical Directo will receive copies of the Wee QA meetings that addresses t monitoring of this tag. He atter the quarterly QA meetings and always has an opportunity to a questions and voice concerns	rges II be 14 t t t t t t d d d d d d d d d d t d tor tor r kly he ends d ask

Event ID: 7R2S11 Facility ID: 000030

If continuation sheet Page 25 of 31

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	ILDING NG	00	CON 10/2	(X3) DATE SURVEY COMPLETED 10/22/2014	
	provider or supplief 1 MANOR	ł	222 PA	ADDRESS, CITY, STATE, ZIP RKVIEW ST PUTH, IN 46563	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFRENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	During an interv 10:25 A.M., CN not sure what the were to prevent However, she in Assignment Car the head of the b would be includ During an interv 10:28 A.M., Uni the resident used her room and a v transfer/ambulat further indicated herself and decid device she woul On 10-20-14 at 3 the CNA Assign head of bed for 1	d/Careplan was located at bed and the interventions ed on the form. iew, on 10-20-14 at t Manager #12 indicated I a wheelchair outside of valker to e in her room. She the resident transferred ded which assistive					
	reach and remin assistance if nee Assignment Car resident was to u ambulating in he	lear, call light within d resident to ask for ded. The CNA d did not indicate the use a walker when er room or a wheelchair g in the hallways.					
	-	iew, on 10-21-14 at 1:20 Director of Nursing)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG indicated all interventions to prevent a fall should have been added to the careplan, including assistive devices. The DON further indicated the CNA Assignment Card would also have been updated to include interventions such as assistive devices. The DON could not explain why Resident # 64's careplan nor CNA Assignment Card did not include the use of a walker or wheelchair with ambulation prior to the fall. 3.1-45(a)(2)F000431 483.60(b), (d), (e) SS=D DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7R2S11 Facility ID: 000030 If continuation sheet Page 27 of 31

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 155073 10/22/2014 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 222 PARKVIEW ST **PILGRIM MANOR** PLYMOUTH. IN 46563 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 1. Residents #13, 39, 47 and 78 F000431 11/20/2014 were not affected by this alleged Based on observation, interview and deficient practice. The medicine record review, the facility failed to ensure bottles have been changed to there was an accurate system for liquid reflect the correct dosage. 2. All residents who have a physician's narcotic reconciliation. This deficient order for a liquid narcotic have practice affected 2 of 2 halls in the the potential to be affected by this facility. alleged deficient practice. There are no other residents with these orders except those identified in Finding includes: #1. 3. William Herman, RPH, **Controlled Substance** During the observation of the medication Compliance Officer with carts for both the East and West nursing **Omnicare Pharmacy in South** units, conducted on 10/20/2014 between Bend, Indiana, acknowledges that the stock bottles from the 2:19 - 3:15 P.M., the following was manufacturer are over filled. He noted: has completed in-service training with his staff on this matter. The education included instructing On Medication cart #1, a cart for the them to fill individual dispensing West unit, the liquid narcotic pain containers to exactly 30 ml. The medication for Resident #74 observed in bottle for future use in Pilgrim a vial appeared to have what looked like Manor will contain 30 ml, avoiding 28 ml's (milliliters) of medications. The overfill/count issues. Kori Hauersperger, RPH, Pharm DH, liquid was noted to be between the 24 Consultant Pharmacist from and 30 ml hashmarks but was closer to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7

7R2S11 Fac

1 Facility ID: 000030

030 If conti

If continuation sheet Page

Page 28 of 31

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 155073 100

PRINTED: 11/19/2014 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/22/2014
	provider or supplie / MANOR	R	222 P/	CADDRESS, CITY, STATE, ZIP CODE ARKVIEW ST OUTH, IN 46563	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		mark. LPN #3 indicated it		Omnicare for our facility was consulted on this matter. She	
		ut 28. The Narcotic		has instructed us to inspect ea	
	record sheet ind	licated there should have		new liquid controlled substance	
	only been 25.75	ml of medication left in		bottle dispensed to ensure it	
	the container.			contains only the amount on the	ne
				label before accepting it from t	he
	On Medication	cart #3, on the East unit,		pharmacy. Pilgrim Manor will	
		tic pain medication for		refuse to accept any liquid narcotic bottle delivered to us	that
	-	ontained just barely under		upon visual inspection contain	
				an overfill. A new policy	5
		ark. The narcotic record		"Accepting Delivery of Liquid	
		there should have only		Controlled Substance" has been	en
	been 2 ml's left	in the bottle. There was		developed. This policy include	es
	also an unopene	ed bottle of the same		the procedure to follow for	
	liquid narcotic i	nedication, Roxanol, for		inspection of each new bottle	to
	Resident #13 w	hich contained over 30		ensure it contains only the	
	ml's of medicati	ion. However, the		amount on the label before accepting it, and the steps to	
		rcotic record sheet		follow for refusing a bottle (See	e
	-	was only 30 ml's		Exhibit 16). The "Controlled	-
				Substances; End of Shift Cour	nt"
	dispensed in the	e bottle.		policy has been revised to incl	ude
				the procedure for measuring	
		cart #4, RN #4 and RN #5		liquid controlled substances be	
	were noted to b	e in the middle of the		unopened and opened bottles regards to the dropper to obtain	
	daily narcotic m	nedication count process.		more accurate readings (See	
	RN #4, who wa	s reading the narcotic		Exhibit 17). Also added to the	
	count sheet amo	ounts to RN #5, who was		policy is that there will be inter	
		edications, indicated the		notification to all nurse manag	ers
	-	Roxanol medication for		when there has been a count	
	•	Resident #39 was to have 11 ml of		correction completed. This	
				notification will include date an time, the concern, who was	iu
	medication. However, RN #5 indicated there was just under 16 ml's of the		notified and the date and time	of	
				the notification. All nurses will	
		ne bottle. RN #4		in-serviced on 11-12-14 through	
		oxanol bottles were		11-14-14 on the "Accepting	
	overfilled but th	e narcotic record sheet		Delivery of Liquid Controlled	
	amounts and the	e visualized amounts were		Substance" and "Controlled	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7R

7R2S11 Facilit

Facility ID: 000030

If continuation sheet Pa

Page 29 of 31

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155073	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/22/2014	
NAME OF	PROVIDER OR SUPPLIE	222 PARKVIEW ST				
PILGRI	/I MANOR		PLYM	OUTH, IN 46563		
X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	more accurate a There was no o explanation giv the facility's po- inaccurate Roxa reconciliation a liquid narcotic r bottle for Resid contain over 30 However, the n form indicated f contained 28.75 On 10/22/14 at the facility polie "Controlled Sul Count, dated 06 oncoming nurse to visualize the the off going nu confirm the am- amount remaini individual coun indicated if the between the vis narcotic count r QMA was to ve then a "count co was to be addeo record and sign members. The immediately no	the bottle was emptied. ther process or en to the discrepancy or licy regarding the		Substances; End of Shift Co policies. 4. The appropriate Manager will be given any pharmacy manifest delivery that were from a liquid contr substance, refused delivery was the result of an overfill. count corrections shall be reported to an in-house nurs manager or the "on call" nur manager. In addition there an internal notification to all managers of such. The Unit Managers will report weekly weekly QA (See Exhibit 10) Committee meeting of any li controlled substance refusal from the pharmacy. The Nur Managers (Director of Nursi East and West Unit Manage MDS Coordinator and Staff Development Coordinator) w report weekly to the weekly (See Exhibit 10) of any cour corrections. The weekly QA Committee is represented by Administrator, Director of Nu (DON), Unit Managers, MDS Coordinator, Staff Developm Coordinator, Staff Developm Coordinator, Medical Records, Activity Director, Business Office Manager, S Service Director and Dietary Manager. The Medical Dire will receive copies of the We QA meetings that addresses monitoring of this tag. He att the quarterly QA meetings a always has an opportunity to questions and voice concern	vunt" e Unit slips, olled that All se se will be nurse t to the quid s rse ng, rs, vill QA at y: ursing bent ocial ntal ctor eekly s the sends nd b ask	

Event ID: 7

7R2S11 Facility ID:

Facility ID: 000030

If continuation sheet

Page 30 of 31

PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155073		(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2014	
NAME OF PROVIDER OR SUPPLIER PILGRIM MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 222 PARKVIEW ST PLYMOUTH, IN 46563		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
	nurse, LPN #6, the Roxanol sor "overfilled" who pharmacy but th place that she w for the overage	e Staff Development indicated she was aware netimes seemed to be en delivered from the here was no policy in vas aware of, to account to ensure the narcotic cy could be followed to 7.			

2S11 Facility ID: 000030

0030 If continuation sheet

nuation sheet Page 31 of 31