STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155073		A. BUILDING <u>00</u>		COMPL	(3) DATE SURVEY COMPLETED 08/28/2024	
NAME OF PROVIDER OR SUPPLIER PILGRIM MANOR	₹		222 PAI	ADDRESS, CITY, STATE, ZIP COD RKVIEW ST UTH, IN 46563		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	TE	(X5) COMPLETION DATE
IN00441511, IN004 IN00439878, and II Complaint IN00441 related to the allega Complaint IN00441 related to the allega F609, and F610. Complaint IN00440 the allegations are of Complaint IN00443 the allegations are of Complaint IN00444 the allegations are of Complaint IN00444 the allegations are of	1511 - Federal/State deficiencies ations are cited at F689. 1555 - Federal/State deficiencies ations are cited at F604, F607, 10897 - No deficiencies related to cited. 10753 - No deficiencies related to cited. 10878 - No deficiencies related to cited. 1571 - No deficiencies related to cited.	F 00	000	By submitting the enclosed materials, we are not admitting truth or accuracy of any specifindings or allegations. We rest the right to contest the findings allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The fact requests the plan of correction considered our allegation of compliance effective Septemb 21, 2024, for the complaint sur completed August 28, 2024. Pilgrim Manor would like to respectfully request a desk review/paper compliance of the plan of correction.	ic erve s or illity i be er er	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

James Combs MBA HFA Administrator 09/25/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155073	B. W	ING _		08/28/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			RKVIEW ST		
PILGRIM	MANOR				DUTH, IN 46563		
I ILOI (IIVI	1717 (1 1 0 1 1			LIMO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	Other: 24						
	Total: 69						
	TI 1 (" ' '	G 4 G 4 E' 1' '4 1'					
		reflect State Findings cited in					
	accordance with 410	0 IAC 16.2-3.1.					
	Quality Pariany	nulated on 0/4/2024					
	Quanty Keview con	mpleted on 9/4/2024					
F 0604	483.10(e)(1), 483.	12(a)(2)					
SS=D		rom Physical Restraints					
Bldg. 00		Hydiddi Nadiriillo					
] ,,,	Based on interviews	s and record review, the facility	F 06	504	It is the practice of this facility	to	09/21/2024
		f 1 residents reviewed for			treat residents with respect an		05,21,202
		from physical restraints,			dignity including the right to be		
	(Resident C).	·			free of physical restraints unle		
	•				required to treat the resident's		
	Finding includes:				medical symptoms		
	-	on 8/22/24 at 8:45 A.M.,			The corrective action(s)		
		ated Resident C, had been			accomplished for the reside		
		lchair with a sheet by two			found to have been affected	by	
		ployee 16 indicated on the			the deficient practice:		
	-	Employees 4 and 5 placed a					
		esident C while he was in his			Resident C no longer resides	in	
		ployee 4 tied the sheet around			the facility. Employee 4 is no		
		r, while the resident was on			longer employed at the facility		
		ing) for supervision. Employee Employee 14 took the resident			How are other residents havin	y tne	
		the East Wing, it was			potential to be affected by the same deficient practice identifi	ied	
		t was tied around the back of			and what corrective action(s)		
		e 14 then reported the incident			be taken;	v 111	
		d 16. Employee 16 indicated			All residents have potential to	be	
		ted the incident to the			affected by the deficient practi		
		ediately, but neither Employee 4			Facility-wide interviews of all		
		re sent home pending an			residents and staff conducted	with	
	investigation.				no restraint use identified. For		
	-				those residents unable to be		
	During an interview	y, on 8/22/24 at 1:00 P.M.,			interviewed, families were		
	Employee 5 indicate	ed she had worked the day			interviewed regarding knowled	lge of	
	shift on 8/13/24 who	en Resident C was being			any restraint use in the issues	_	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155073	B. W	ING _		08/28/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			RKVIEW ST		
	MANOR				NKVIEW 51 DUTH, IN 46563		
I ILGINIVI	INICINOIN			LLING			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
	_	est hall. Employee 5 indicated			identified and skin checks		
		ching for things, was very			completed		
		hair, and he kept trying to					
	_	heelchair. Employee 5			What measures will be put in	ito	
	_	iving shift report to Employee			place and what systemic		
	4 while supervising Resident C, who was very active in his chair. Employee 5 indicated				changes will be made to ens		
					that the deficient practice do	es	
		ed sheet from the linen closet			not recur;		
		yee 4 folded the sheet in a					
		out it over the resident's lap			The facility policy on abuse,		
	while he was in his wheelchair. Employee 5 indicated Employee 4 then tied the ends of the				includi the use of restraints, w		
					reviewed by the IDT and upda		
	sheet together around the back of the resident's wheelchair. Employee 5 demonstrated folding a				An in-service conducted by the		
		_			Administrator with all facility st		
		n elongated triangle, then			on the policy and its changes	on	
		she and Employee 4 placed it			or before 9/10/2024. Any	4la a	
		s lap and how Employee 4 tied			employees who did not attend		
	_	ehind the back of the yee 5 indicated the resident was			in-service will be in-serviced b	-	
		to keep the resident from			Administrator or his/her design		
		from getting up out of the			before working. A performance	æ	
	wheelchair.	from getting up out of the			improvement tool has been developed to monitor resident	c aro	
	wheelenan.				free of restraint any allegation		
	During a telephone	interview, on 8/22/24 at 4:06			abuse have been reported. Th		
		ndicated she and Employee 5			performance tool will also sho		
		eet over Resident C's lap to			staff understanding of the abu		
		Employee 4 indicated she tied			policy and proper reporting.		
		et together at the back of the			Fine, and proper reporting.		
		e the sheet and it was not			How the corrective actions w	vill	
		e resident from moving or from			be monitored to ensure the		
		e chair. Employee 4 indicated			deficient practice does not		
		e to move around while seated			recur;		
	in his chair with the	sheet in place. Employee 4			Frequency and duration of		
		gh the sheet was over him and			reviews will be increased as		
	tied together at the	back of his wheelchair, it was			needed if any areas of		
	not meant to keep h	im from moving in the			noncompliance are identified		
	wheelchair and indicated it (the use of the tied bed				during the monitoring process		
		ow you perceive it."			Frequency and duration of rev		
					will be increased as needed if		
	During an interview	y, on 8/22/24 at 3:40 P.M., the			areas of noncompliance are	•	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155073	B. W	ING		08/28	/2024
		<u>I</u>	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			RKVIEW ST		
PILGRIM	I MANOR				NUTH, IN 46563		
FILGRIN	INITION			LLINO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		g indicated if Resident C had			identified during the monitoring	g	
		wheelchair utilizing a bed			process.		
		ion was inappropriate and			The results of these reviews w		
	should have been re	eported to management.			discussed at the monthly facili	-	
					Quality Assurance Committee		
	_	v on 8/23/24 at 5:00 P.M.,			meeting monthly for three mor		
		ated, on 8/14/24, it was reported			and then quarterly thereafter f	or a	1
		24, Employee 4 had tied			total of 6 months.		
	Resident C to his w	heelchair with a sheet			By what date the systemic		
					changes for the deficiency will	be	
	_	v on 8/26/24 at 8:45 A.M., the			completed:¿		
	Administrator, indicated the incident involving				9/21/2024		
	Resident C being tied to his wheelchair was						
	1 -	and 8/13/24. She indicated it					
		byee 5 had used a bed sheet to					
		o his wheelchair. The					
		eated she believed on 8/7/24,					
		reported that Employee 4 had					
	1 -	Resident C's lap and tied the					
		neelchair. The Administrator					
		tor of Nursing did interview					
		dministrator indicated the					
	· ·	vestigate the allegations any					
	further.						
	TE1 1' ' 1 ' 1	C D :1 (C : 1					
		for Resident C was reviewed					
		A.M. Diagnoses included,					
		opathy, seizure disorder,					
	anxiety, and obstrue	ctive uropathy.					
	An Admission Min	imum Data Sat (MDS)					
		imum Data Set (MDS)					
		/17/24, indicated Resident C					
		tively impaired, displayed					
		ns not directed toward others					
	and the behaviors did not put the resident at risk						
	nor interfere with the resident's care, but did						
	interfere with the resident's participation in social						
		ent C's behaviors did disrupt					
	_	nent and the activities of others.					
	Resident C demons	trated rejection of care,					1

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155073		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/28/2024	
	PROVIDER OR SUPPLIER		222 PA	ADDRESS, CITY, STATE, ZIP COD ARKVIEW ST OUTH, IN 46563		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	wandering, and sign privacy of others. R others for most active ating, bathing, and dependent on a whe for locomotion need. A review of the, An Association (APNA Practice: Seclusion revised 3/22, indica qualified staff authorinitiate seclusion or emergency and must a physician or Licer responsible for the operson"	nificantly intruded on the esident C was dependent on vities of daily living, including toileting. The resident was elchair and staff assistance				
F 0607 SS=D Bldg. 00		nt Abuse/Neglect Policies	F 0607	="" b="">	00/21/2024	
	policy review, the f abuse policy was in report an allegation use of a physical res	s, record review, and facility facility failed to ensure their applemented when staff failed to of abuse regarding an alleged straint, to the State Agency, reviewed for abuse, (Resident	F 0607	It is the practice of this facility to follow the abuse policy by reporting the use of an alleged physical restraint or any allega of abuse to the State Agency. The corrective action(s) accomplished for the resident found to have been affected in the deficient practice:	tion u t	
	Employee 16 indica secured to his whee staff members. Emp	on 8/22/24 at 8:45 A.M., tted Resident C, had been lchair with a sheet by two ployee 16 indicated on the Employees 4 and 5 placed a		Resident C no longer resides in the facility. Employee 4 is no longer employed. How are other residents havi		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155073	B. W	ING		08/28/	2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R			RKVIEW ST		
PILGRIM	1 MANOR				OUTH, IN 46563		
	1				I	П	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		esident C while he was in his			the potential to be affected b	by .	
		ployee 4 tied the sheet around			the same deficient practice		
		r, while the resident was on			identified and what corrective	re	
		ring) for supervision. Employee			action(s) will be taken;	l of	
		Employee 14 took the resident to the East Wing, it was			All residents have the potentia		
		et was tied around the back of			being affected by the deficient practice. Employees involved		
		the 14 then reported the incident			abuse allegation will be removed		
		nd 16. Employee 16 indicated			from the schedule pending	-cu	
		ted the incident to the			investigation. The Administrat	or or	
		ediately, but neither Employee 4			designee will report the allega		
	nor Employee 5 were sent home pending an				into Gateway following state		
	investigation.	10 sent nome pending un			reportable guidelines.		
	mvestigation.				Toportable galdelines.		
	During an interview, on 8/22/24 at 1:00 P.M.,				What measures will be put in	nto	
	_	ed she had worked the day			place and what systemic		
		en Resident C was being			changes will be made to ens	ure	
		vest hall. Employee 5 indicated			that the deficient practice do		
	-	ching for things, was very			not recur;		
	active in his wheeld	chair, and he kept trying to			The facility policy on abuse, w	hich	
	stand up from the w	vheelchair. Employee 5			includes reporting guidelines,	was	
	-	iving shift report to Employee			reviewed by the IDT and upda	ited.	
		Resident C, who was very			An in-service was conducted l	-	
		Employee 5 indicated			the Administrator with all facili	-	
		ed sheet from the linen closet			staff on the policy and its char	nges	
		yee 4 folded the sheet in a			on or before 9/10/2024. Any		
		out it over the resident's lap			employees who did not attend		
		wheelchair. Employee 5			in-service will be in-serviced b	-	
		e 4 then tied the ends of the			Administrator or his/her design		
	_	nd the back of the resident's			before working. A performanc	е	
		yee 5 demonstrated folding a			improvement tool has been		
		in elongated triangle, then			developed to monitor that		
		she and Employee 4 placed it			residents are free of restraint	-	
		s lap and how Employee 4 tied			and that any allegations of ab	use	
	the sheet together behind the back of the				have been reported. The		
	wheelchair. Employee 5 indicated the resident was				performance tool will also sho		
	secured to the chair to keep the resident from falling forward and from getting up out of the				staff understanding of the abu	se	
	_				policy and proper reporting.		
		yee 5 indicated it was Employee resident to his wheelchair.			How the corrective actions v	vill	
1	T WHO HAD UCU THE	resident to his wheeleliall.			i now me corrective actions v	VIII	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155073	B. W	ING		08/28/	2024
		1		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			RKVIEW ST		
PILGRIM	I MANOR				OUTH, IN 46563		
	1				T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ed she had not reported the			be monitored to ensure the		
		ctor of Nursing or the			deficient practice does not		
		use she would have gotten in			recur;		
		For her job. Employee 5			Newly hired nursing associate	es	
		ever been interviewed by			will be provided with abuse		
	occurred on 8/13/20	ling the incident since it had			education including use of		
	occurred on 6/13/2024.				restraints during the general	_!	
	During a telephone interview, on 8/22/24 at 4:06				orientation process as an ong	•	
					process. Administrator/design	ee	
	P.M., Employee 4 indicated she and Employee 5 had placed a bed sheet over Resident C's lap to				will complete routine staff	naira	
	give him "dignity." Employee 4 indicated she tied				interviews utilizing a question as to what constitutes a restra		
	the ends of the sheet together at the back of the				to ensure they remain	11111	
	wheelchair to secure the sheet and it was not				knowledgeable of reporting		
		e resident from moving or from			requirements regarding use of	f	
	_	e chair. Employee 4 indicated			physical restraints. Interviews		
		le to move around in his chair			occur: 5 random associates	lO	
		ace. Employee 4 indicated			weekly x's 30 days, then 5		
	_	eet was over him and tied			random associates monthly x'	° 6	
		of his wheelchair, it was not			months of monitoring. Any fine		
	_	from moving in the wheelchair			will be addressed. Frequency	-	
	_	e use of the tied bed sheet)			duration of reviews will be	and	
	was, "all in how you				increased as needed if any ar	eas	
	was, an mnew ye	a perceive ia			of noncompliance are identifie		
	During an interview	v, on 8/22/24 at 3:40 P.M., the			during the monitoring		
	_	; indicated she had no prior			process. The		
	_	neident involving Resident C			Administrator/designee will		
		e indicated if Resident C had			complete routine physical		
	-	wheelchair utilizing a bed			observations of residents to		
		on was inappropriate and			ensure physical restraints are	not	
		eported to management.			in use, unless appropriately		
					ordered and if inappropriate u	se	
	During an interview	v on 8/23/24 at 5:00 P.M.,			has been identified, that it was		
	_	ated, on 8/14/24, it was reported			reported timely per reporting		
		24, Employee 4 had tied			guidelines. Monitoring to occu	ır: 5	
		heelchair with a sheet.			random residents weekly x's 3		
	Employee 13 indicated the Director of Nursing				days, then 5 random residents		
		cident because on 8/14/24, the			monthly x's 5 months for a total		
		had discussed suspending			6 months of monitoring. Any		
	_	ovee 13 indicated she did not			findings will be addressed		

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	PROVIDER OR SUPPLIER		222 PA	ADDRESS, CITY, STATE, ZIP COD NRKVIEW ST DUTH, IN 46563	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the Director of Nurse Administrator, indice Resident C being the reported to her arous was reported Employed secure Resident C to Administrator indice footage of Employed bed sheet over Resident C to Administrator indice footage of Employed bed sheet over Resident Administrator indice Employed 16 report over Resident C's latthe wheelchair. The Director of Nursing Administrator indice investigate the allegen The clinical record on 8/26/24 at 11:18 dementia, encephaloanxiety, and obstruction Administrator indice investigate the allegen The clinical record on 8/26/24 at 11:18 dementia, encephaloanxiety, and obstruction An Admission Minimassessment dated 7/ was severely cognition behavioral sympton and the behaviors donor interfere with the interfere with the interfere with the reinteractions. Resident C demonst wandering, and sign wandering, and sign	for Resident C was reviewed A.M. Diagnoses included, opathy, seizure disorder,		Frequency and duration of revital be increased as needed it areas of noncompliance are identified during the monitoring process. The results of these reviews we discussed at the monthly facil Quality Assurance Committee meeting monthly for three monand then quarterly thereafter it total of 6 months. By what date the systemic changes for the deficiency will completed: 2, 9/21/2024	rany g vill be ity e nths for a

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NAME OF P	ROVIDER OR SUPPLIER		222 PA	ADDRESS, CITY, STATE, ZIP COD RKVIEW ST OUTH, IN 46563	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	eating, bathing, and	vities of daily living, including toileting. The resident was elchair and staff assistance is.			
	provided a policy tire. Procedure," dated the current facility properties in the will confinementInvest madethe employes suspended, pending investigationReport that all staff recognitations of abuse the Administrator made the facility is appropriate officials.	orting/Response It is essential fize the importance of such a report immediately to Once the allegation has been responsible to notify the such as the such a responsible to notify the such as the su			
	3.1-28(a) 3.1-28(c) 3.1-28(d) 3.1-28(e)	to Complaint IN00441555.			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(Reporting of Alleg				
J	failed to report to the of abuse for 1 of 3 re (Residents C). Finding includes: During an interview Employee 16 indicates	s and record review, the facility are State Agency an allegation resident's reviewed for abuse, on 8/22/24 at 8:45 A.M., ated Resident C, had been	F 0609	F 609 Reporting of Alleged Violations It is the practice of this facility report all alleged violations involving abuse to the State Agency in the appropriate amo of time after any allegation is made. The corrective action(s)	
	secured to his wheelchair with a sheet by two			The corrective action(s)	

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			l í			<u> </u>		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		155073	B. W	ING		08/28/	/2024	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
		-			RKVIEW ST			
PILGRIM	MANOR			PLYMO	OUTH, IN 46563			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	VIE.	DATE	
	staff members. Emp	ployee 16 indicated on the			accomplished for the reside	nt		
	evening of 8/13/24, Employees 4 and 5 placed a				found to have been affected	by		
	sheet around the Resident C while he was in his				the deficient practice:			
	wheelchair and Employee 4 tied the sheet around			The Administrator entered the				
	the back of the chair, while the resident was on				allegations of abuse for Resid	ent		
	their wing (West W	ring) for supervision. Employee			C in the Gateway portal on			
	16 indicated when Employee 14 took the resident				8/26/24.			
	back to his room on the East Wing, it was							
		et was tied around the back of			How are other residents hav	ing		
	the chair. Employee 14 then reported the incident				the potential to be affected b	•		
	to Employees 15 and 16. Employee 16 indicated				the same deficient practice	•		
Employee 15 reported the incident to the				identified and what corrective	⁄e			
	Administrator immediately, but neither Employee 4				action(s) will be taken;			
	nor Employee 5 were sent home pending an				All residents have the potentia	al of		
	investigation.	1 8			being affected by the deficient			
	iii v estigationi				practice. A facility-wide audit v			
	During an interview	v, on 8/22/24 at 1:00 P.M.,			conducted to ensure there we			
	-	ed she had worked the day			additional violations. No additi			
		en Resident C was being			allegations found.	oriai		
		vest hall. Employee 5 indicated						
	_	ching for things, was very			What measures will be put in	nto		
		chair, and he kept trying to			place and what systemic	110		
		wheelchair. Employee 5			changes will be made to ens	ruro		
	-	iving shift report to Employee			that the deficient practice do			
	_	Resident C, who was very			·	<i>)</i> es		
		Employee 5 indicated			not recur; The facility policy on abuse, w	hich		
		ed sheet from the linen closet			includes reporting guidelines,			
		yee 4 folded the sheet in a			reviewed by the IDT and upda			
		out it over the resident's lap						
		wheelchair. Employee 5			An in-service was conducted I	-		
					the Administrator with all facili	-		
		e 4 then tied the ends of the			staff on the policy and its char	iges		
	_	nd the back of the resident's			on or before 9/10/2024. Any	1 41		
		yee 5 demonstrated folding a			employees who did not attend			
		in elongated triangle, then			in-service will be in-serviced b	-		
		she and Employee 4 placed it			Administrator or his/her design			
		s lap and how Employee 4 tied		before working. A performand		ce		
	the sheet together behind the back of the				improvement tool has been			
		yee 5 indicated the resident was			developed to monitor resident	s are		
		to keep the resident from			free of restraint use, and any			
	falling forward and	from getting up out of the			allegations of abuse have bee	n		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155073	B. WI	NG		08/28/	2024
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			RKVIEW ST		
PILGRIM	MANOR				OUTH, IN 46563		
(VA) ID	CUMMADY	STATEMENT OF DEFICIENCIE	<u> </u>		I		(Y5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAU		yee 5 indicated it was Employee	_	IAU	reported. The performance too	ol will	DATE
		resident to his wheelchair.			also show staff understanding		
		ed she had not reported the			_		
		ctor of Nursing or the			abuse policy and proper repor	ung.	
		use she would have gotten in			How the corrective actions v	:11	
		For her job. Employee 5				VIII	
					be monitored to ensure the		
	indicated she had never been interviewed by management regarding the incident since it had				deficient practice does not		
	occurred on 8/13/2024.				recur;		
	occurred on 8/13/2024.				Administrator/designee will	4/0	
	During a talanhana interview, on 8/22/24 at 4:06				complete routine staff interview		
	During a telephone interview, on 8/22/24 at 4:06 P.M., Employee 4 indicated she and Employee 5				utilizing a questionnaire as to		
	1				constitutes a restraint to ensur		
	had placed a bed sheet over Resident C's lap to give him "dignity." Employee 4 indicated she tied				they remain knowledgeable of		
					reporting requirements regard	ing	
		et together at the back of the			use of physical restraints.		
		e the sheet and it was not			Interviews to occur: 5 random		
	_	e resident from moving or from			associates weekly x's 30 days		
		e chair. Employee 4 indicated			then 5 random associates mo	-	
		le to move around in his chair			x's 6 months of monitoring. Ar	ıy	
		ace. Employee 4 indicated			findings will be addressed.		
	_	eet was over him and tied			Frequency and duration of rev		
	_	of his wheelchair, it was not			will be increased as needed if	any	
	_	from moving in the wheelchair			areas of noncompliance are		
	· ·	e use of the tied bed sheet)			identified during the monitoring	g	
	was, "all in how yo	u perceive it."			process. The		
	Dumin a. a.: : '	on 9/22/24 at 2:40 D.M. 41-			Administrator/designee will		
	_	y, on 8/22/24 at 3:40 P.M., the			complete routine physical		
	_	indicated she had no prior			observations of residents to	not	
		ncident involving Resident C			ensure physical restraints are	HOL	
	· ·	e indicated if Resident C had			in use, unless appropriately	•	
		wheelchair utilizing a bed			ordered and if inappropriate us		
		on was inappropriate and			has been identified, that it was	S .	
	should have been re	eported to management.			reported timely per reporting	r. E	
	Duning on intermi	y on 9/22/24 at 5:00 D.M. with			guidelines. Monitoring to occu		
	_	on 8/23/24 at 5:00 P.M., with			random residents weekly x's 3		
		nted, on 8/14/24, it was reported			days, then 5 random residents		
		24, Employee 4 had tied			monthly x's 5 months for a total	ai ot	
		heelchair with a sheet.			6 months of monitoring. Any		
		ated the Director of Nursing			findings will be addressed		
l	I was aware of the in	cident because on 8/14/24, the			By what date the systemic		

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

PRINTED: 10/03/2024 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155073	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 8/2024
	PROVIDER OR SUPPLIEF		222 PA	ADDRESS, CITY, STATE, ZIP C ARKVIEW ST DUTH, IN 46563	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	Precion of Nursing Employee 4. Employee 4. Emplore the incident of the Director of Nursing Employee 4. Emplore port the incident of the Director of Nursing an interview Administrator, indicated the Property of the Property			changes for the deficie completed: ¿ 9/21/2024		
	was severely cognit behavioral sympton and the behaviors d nor interfere with the	/17/24, indicated Resident C rively impaired, displayed ans not directed toward others id not put the resident at risk are resident's care, but did esident's participation in social				

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

Event ID:

CXJS11

Facility ID: 000030

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155073		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 08/28/2024					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 222 PARKVIEW ST PLYMOUTH, IN 46563				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIATE OF T	(X5) COMPLETION DATE		
	the living environm Resident C demons wandering, and sign privacy of others. R others for most active teating, bathing, and dependent on a where for locomotion needs. On 8/22/24 at 9:00 provided a policy ting the current facility provided a policy ting. The confinement of the current facility provided is the will confinement. Invest It is essential that all importance of alleging immediately to the allegation has been responsible to notification.	A.M., the Administrator tled, "Abuse Prevention Policy 13/20/24 and indicated it was policy. The policy indicated, ful infliction ofunreasonable tigationReporting/Response 1 staff recognize the ations of abuseand report AdministratorOnce the					
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prever	nt/Correct Alleged Violation					
	failed to ensure a th completed for an all	nd record review, the facility orough investigation was legation of abuse for 1 of 3 for abuse, (Resident C).	F 0610	It is the practice of this facility follow the abuse policy by reporting the use of an allege physical restraint or any alleg of abuse to the State Agency.	d ation		
	During an interview Employee 16 indica secured to his whee	on 8/22/24 at 8:45 A.M., ted Resident C, had been lchair with a sheet by two bloyee 16 indicated on the		The corrective action(s) accomplished for the reside found to have been affected the deficient practice: Resident C no longer resides	l by		

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

Event ID:

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Facility ID: 000030

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If continuation sheet Page 13 of 21

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155073	B. W	B. WING		08/28/2024	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			RKVIEW ST		
PILGRIM MANOR							
PILGRIN	IWANOR			PLYIMO	OUTH, IN 46563		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	evening of 8/13/24,	Employees 4 and 5 placed a			the facility. The staff member		
	sheet around the Re	sident C while he was in his			failing to report allegation of a	buse	
	wheelchair and Em	ployee 4 tied the sheet around			is no longer employed at the		
		r, while the resident was on			facility.		
		ing) for supervision. Employee					
	16 indicated when	Employee 14 took the resident			How are other residents hav	ing	
		the East Wing, it was			the potential to be affected b	by	
	discovered the shee	t was tied around the back of			the same deficient practice		
		e 14 then reported the incident			identified and what corrective	⁄e	
		d 16. Employee 16 indicated			action(s) will be taken;		
		ted the incident to the			All residents have the potentia	al of	
		ediately, but neither Employee 4			being affected by the deficient	t	
		re sent home pending an		practice. Employees involved in an			
	investigation.			abuse allegation will be removed		/ed	
			from the schedule pending				
	_	y, on 8/22/24 at 1:00 P.M.,	investigation. The Administrator or				
		ed she had worked the day		designee will report the allegation			
		en Resident C was being			into Gateway following state		
	1 -	est hall. Employee 5 indicated			reportable guidelines.		
		ching for things, was very					
		chair, and he kept trying to			What measures will be put into		
		heelchair. Employee 5	place and what systemic				
	_	iving shift report to Employee	changes will be made to ensure				
		Resident C, who was very			that the deficient practice do	es	
		Employee 5 indicated			not recur;		
		ed sheet from the linen closet	The facility policy on abuse, whic				
		yee 4 folded the sheet in a		includes reporting guidel			
		out it over the resident's lap		reviewed by the IDT and update			
		wheelchair. Employee 5			An in-service was conducted b	-	
		4 then tied the ends of the		the Administrator with all facility		-	
		nd the back of the resident's			staff on the policy and its char	nges	
		vee 5 demonstrated folding a			on or before 9/10/2024. Any		
		n elongated triangle, then			employees who did not attend		
		she and Employee 4 placed it			in-service will be in-serviced b	-	
		's lap and how Employee 4 tied			Administrator or his/her design		
	_	ehind the back of the			before working. A performance	e	
		vee 5 indicated the resident was			improvement tool has been		
		to keep the resident from			developed to monitor resident		
	_	from getting up out of the			free of restraint use, and that		
wheelchair. Employee 5 indicated it was Employee				allegations of abuse have bee	n		

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Event ID:

CXJS11 Facility ID: 000030

If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155073	B. W	ING		08/28/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			RKVIEW ST		
	I MANOR				NKVIEW 51 OUTH, IN 46563		
FILGKIM	I IVIAINOR			FLTIVIO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	4 who had tied the	resident to his wheelchair.			reported. The performance too	ol will	
	Employee 5 indicat	ed she had not reported the			show staff understanding of th	е	
		ctor of Nursing or the			abuse policy and proper repor	ting.	
		use she would have gotten in					
		for her job. Employee 5			How the corrective actions w	vill	
		ever been interviewed by			be monitored to ensure the		
	management regard	ling the incident since it had			deficient practice does not		
	occurred on 8/13/20	024.			recur;		
	During a telephone	interview, on 8/22/24 at 4:06			The Administrator/designee w	ill	
		ndicated she and Employee 5			complete routine auditing to		
		eet over Resident C's lap to			ensure that allegations of abus	20	
	•	Employee 4 indicated she tied			are completely investigated wi		
		et together at the back of the		the 5 day follow up time period.			
		e the sheet and it was not		The facility will utilize an abuse			
		e resident from moving or from			checklist for allegations of abu		
		e chair. Employee 4 indicated			Auditing to occur: 5 abuse		
		le to move around in his chair			allegations weekly if they occu	ır	
		ace. Employee 4 indicated			x's 30 days, then 5 abuse	•	
	_	eet was over him and tied			allegations, if they occur mont	hlv	
		of his wheelchair, it was not			x's 5 months for a total of 6	,	
	_	from moving in the wheelchair			months of monitoring. Any find	dings	
	and indicated it (the	e use of the tied bed sheet)			will be addressed Frequency a	-	
	was, "all in how yo	u perceive it."			duration of reviews will be		
					increased as needed if any are	eas	
	During an interview	v, on 8/22/24 at 3:40 P.M., the			of noncompliance are identifie		
		indicated she had no prior			during the monitoring process		
	knowledge of the in	ncident involving Resident C]		
		e indicated if Resident C had					
	been secured to the	wheelchair utilizing a bed					
	sheet, the interventi	on was inappropriate and					
	should have been re	eported to management.					
	During an interview on 8/23/24 at 5:00 P.M.,						
	Employee 13 indicated, on 8/14/24, it was reported						
		24, Employee 4 had tied					
		heelchair with a sheet.			By what date the systemic		
		ated the Director of Nursing			changes for the deficiency will	l he	
		cident because on 8/14/24, the			completed:	DC	
		had discussed suspending			9/21/2024		

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

PRINTED: 10/03/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155073		A. BUILDING B. WING	COMPLETED 08/28/2024				
NAME OF PROVIDER OR SUPPLIER PILGRIM MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 222 PARKVIEW ST PLYMOUTH, IN 46563				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	Employee 4. Employee the incident to	byee 13 indicated she did not to the Administrator because sing was aware of the incident.			5.112		
	Administrator, indice Resident C being the reported to her arouse was reported Employers around his lap, but the video, Employer restraining Resident Administrator indice Employers 16 report over Resident C's latthe wheelchair. The Director of Nursing	on 8/26/24 at 8:45 A.M., the cated the incident involving ed to his wheelchair was and 8/1324. She indicated it to be 5 had used a bed sheet to on his wheelchair. The cated she reviewed video be 5 and observed her placing a dent C's lap and tucking it in at no time did she observe on the 5 tying the sheet or the C to his wheelchair. The cated she believed on 8/7/24, and that Employee 4 put a sheet up and tied the sheet behind the Administrator indicated the cated the facility failed to gation any further.					
	The clinical record for Resident C was reviewed on 8/26/24 at 11:18 A.M. Diagnoses included, dementia, encephalopathy, seizure disorder, anxiety, and obstructive uropathy.						
	An Admission Minimum Data Set (MDS) assessment dated 7/17/24, indicated Resident C was severely cognitively impaired, displayed behavioral symptoms not directed toward others and the behaviors did not put the resident at risk nor interfere with the resident's care, but did interfere with the resident's participation in social interactions. Resident C's behaviors did disrupt the living environment and the activities of others. Resident C demonstrated rejection of care, wandering, and significantly intruded on the						

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

Event ID:

CXJS11

Facility ID: 000030

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDE		IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLE			ETED	
155073		155073	B. WING			08/28/2024	
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				RKVIEW ST		
PILGRIM	MANOR				UTH, IN 46563		
1 ILOI (IIVI	1007 (1407)				0 111, IIV +0000		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5) COMPLETION
PREFIX	(EACH DEFICIENCY MICT DE DECEDED DY ELL I DEFENY (FACH CO		CROSS-REFERENCED TO THE APPROPRIAT	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	esident C was dependent on					
others for most activities of daily living, including							
	eating, bathing, and toileting. The resident was dependent on a wheelchair and staff assistance						
	for locomotion need						
	for focomotion need	is.					
	On 9/22/24 at 0:00	A.M., the Administrator					
		tled, "Abuse Prevention Policy					
		1 3/20/24 and indicated it was					
		policy. The policy indicated,					
		ful infliction ofunreasonable					
confinementInvestigationOnce an allegation is madethe employee will immediately be							
	suspended, pending	-					
	This citation relates	to Complaint IN00441555.					
	3.1-28(d)						
F 0689	400.05(1)(4)(0)						
SS=D	483.25(d)(1)(2) Free of Accident						
Bldg. 00	Hazards/Supervisi	ion/Dovices					
Diag. 00	•	on, interview, and record	F 0689		F 689 Free of Accident		09/21/2024
	review, the facility f		F UC	009	Hazards/Supervision/Devices		09/21/2024
	•	fee and hot water before			It is the practice of this facility	that	
	serving the fluids to residents and failed to assess				the resident's environment	illat	
	-	aid safety for 1 of 3 residents			remains as free of accident		
		nts. (Resident B) This			hazards as possible and reside	ents	
		sulted in a resident spilling hot			are assessed when accidents		
	liquid onto her lap a	and sustaining ;second degree			occur.		
	burns on her legs. (Resident B)					
					The corrective action(s)		
	Finding includes:				accomplished for the resider	nt	
					found to have been affected	by	
	•	on on 8/22/24 at 2:00 P.M.,			the deficient practice:		
		esident B was laying in her bed			Resident B no longer resides i	n	
		but she did not respond to			the facility.		
	-	oyee 5 pulled the covers back				_	
	-	eas on both of Resident B's			How are other residents havi	-	
	thighs. The upper le	ft thigh had a reddened area			the potential to be affected b	y	

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Event ID:

CXJS11 Facility ID: 000030

If continuation sheet Page 17 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
1550		155073	B. WING 08		08/28/	08/28/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .			RKVIEW ST		
PILGRIM	I MANOR				OUTH, IN 46563		
	T				- , ··· ·		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION approximately 10 cm x 5 cm that covered the top of		+	TAG			DATE
		-			the same deficient practice		
	_	ne inner thigh. A fluid filled			identified and what corrective	⁄e	
		ly 6 cm x 6 cm was noted to the			action(s) will be taken;	-1-	
		f the thigh. The tissue ster was red and raw. The right			All residents are at potential ri	SK	
	_	rea approximately 10 cm x 5			for injury while handling hot		
	_	rea approximately 10 cm x 3			liquids. A hot liquid safety	الم	
	cm.				evaluation was completed on	all	
	During on integrican	y, on 8/23/24 at 5:00 P.M.,			residents. All residents		
	_	ated on 8/18/24, Resident B was			determined to be at risk were referred to therapy for screeni	na	
		the dining room when she			and appropriate interventions.	•	
	_	taining hot tea and burned her			Resident care plans updated.		
	-	13 indicated the resident			Temperature checks of hot liq	uide	
		ersonal, large mug for coffee,		are completed at each meal by			
		ninimal assistance to set up her	dietary department. Hot liquid				
	meal.	minimal assistance to set up ner	mugs with lids have also been				
	meur.				ordered. The hot liquid machi		
	During an interview	on 8/26/24 at 2:00 P.M.,			was serviced and temperature		
	_	ated she takes care of Resident			adjusted.	,	
		oyee 23 indicated Resident B			aujuotou.		
		ling her own cup without			What measures will be put in	nto	
	_	ee 23 indicated the mug must	place and what systemic				
		or the resident to hold, so she	changes will be made to ensure				
	had spilt the hot tea		that the deficient practice does				
		•			not recur;		
	During an interview	on 8/26/24 at 2:14 P.M.,			The facility policy on safety of	hot	
	Employee 22 indica	ated he had been employed in			liquids was reviewed by the ID		
	the kitchen for six y	vears. Employee 22 indicated			An in-service was conducted v		
	the kitchen and dini	ng staff had never checked			all facility staff on the policy ar	nd	
	the temperatures of	the hot liquids accessed from			licensed nurses were in-service	ced	
	the hot water and co	offee dispensers in the kitchen.			on assessing residents		
		nted kitchen staff began			immediately after anA		
		ng hot beverage temperatures			performance improvement too	l has	
	from the kitchen dis	spenser approximately 2 weeks			been developed to monitor		
	ago.				residents are evaluated on		
					admission and at least quarte	rly	
	During an interview	on 8/26/24 at 3:04 P.M., the			for risk for injury while handlin	g hot	
		dicated on 8/18/24 Resident B			liquids and referred to therapy	for	
	_	st in the main dining room by			screening and results added t	o	
	the kitchen. The Dietary Manager indicated				care plan.		

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

PRINTED: 10/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155073		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 08/28/2024						
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 222 PARKVIEW ST PLYMOUTH, IN 46563					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	Resident B had a m spilled the tea onto indicated a local for the hot fluid machin temperatures. The Dietary Manag routinely filled two hot liquid dispenser with hot water. Resand hot water from of the liquids in the The Dietary Manag sustained burns, the temperature of the lithe temperature of the lithe temperature of the local flood service p coffee maker and he informed the local fload so a technic facility until 8/26/2/2. Facility temperature July 2024 through requested on 8/26/2/2 temperature logs provide the Administration indicated there completed prior to 18/18/24. The Admi should have been m temperatures of hot and the carafes to end.	ug of hot tea and she had her lap. The Dietary Manager od service provider maintained hes and regulated the er indicated the kitchen carafes at meal time from the s, one with coffee the other sident were then served coffee the carafes but the temperature carafes had not been checked. Her indicated after Resident B y began monitoring the iquids in the carafes to ensure he fluid was under 180 the facility's acceptable for hot fluids. The Dietary on 8/20/24, she requested the rovider check the facility's of water dispenser but was food service provider was short ian had not come to the 4. He logs of the hot liquids for August 18, 2024 were eld at 3:00 P.M. There were no povided. During an interview stor, on 8/26/24 at 3:32 P.M., were no temperature logs Resident B sustaining burns on istrator indicated the facility conitoring and assessining the liquids from the dispensers usure they were safe.		How the corrective actions be monitored to ensure the deficient practice does not recur; The Food Service Director/designee will comple routine auditing to ensure liquare within the appropriate ran Auditing to occur: 5 random residents weekly x's 30 days, ransom residents monthly x's months for a total of 6 months monitoring. DON/designee to complete routine auditing designee to ensure hot liquid safety evaluations have been completed and at risk resider have interventions in place or care plan. Auditing to occur: 6 random residents weekly x's days, then 5 random resident monthly x's 5 months for a tot 6 months of monitoring. Any findings will be addressed Frequency and duration of re will be increased as needed i areas of noncompliance are identified during the monitoring process. By what date the systemic changes for the deficiency will completed: 9/21/2024	ete uids age. 5 5 5 s of 0 ats atthe 5 30 as tal of views f any			
	Administrator indicated a hot liquid safely evaluation assessment had not been completed for Resident B until after the resident had spilled							

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PRINTED: 10/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155073		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/28/2024				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 222 PARKVIEW ST PLYMOUTH, IN 46563					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPROFICIENCY)	BE COMPLETION			
	indicated the facility temperatures of hot sustained burns on indicated the local for responsible for the persponsible for the perspons	nonitoring of hot liquid Administrator indicated her own personal mug that hids I record was reviewed on Diagnosis included, but were entia, delusional disorder, ognitive impairment.						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
155073		155073	B. WING		08/28/2024		
NAME OF PROVIDER OR SUPPLIER PILGRIM MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 222 PARKVIEW ST PLYMOUTH, IN 46563				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	I		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
1710		I., indicated Resident B had	1710			Ditte	
		s to both thighs above the					
	_	g, inflammation, redness with					
		n non-blanchable with					
	drainage.	in non orangement with					
	On 8/26/24 at 3:11	P.M., the Administrator					
		tled, "Safety of Hot Liquids,"					
		ating it was the current facility					
		ndicated residents would be					
		concerns and potential for					
	injury from hot liqu	-					
		be implemented too maximize					
	_	while minimizing the potential					
		ntial for burns from hot liquids					
		ncern among residents with					
		and musculoskeletal					
	conditions. Residen	its who preferred hot					
	beverages with mea	als would not be restricted form					
	1 -	, staff would conduct regular					
	Hot Liquids Safety	Evaluations as indicated, and					
		actors for scalding and burns					
	in the care plan.						
	Food service staff v	vas to monitor and maintain					
	food temperatures t	hat complied with food safety					
	requirements but di	d not exceed recommended					
	temperatures to pre-	vent scalding.					
		to Complaint IN00441511.					
3.1 - 45(3)(1)(2)		I	i		I		

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