STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00397354. Complaint IN00397354 - Substantiated. Federal/State deficiencies related to the allegations are cited at F686, F692 & F693. Survey dates: February 8, 9, 10, 13, 14, & 15, 2023 Facility number: 000030 Provider number: 155073 AIM number: 100275260 Census Bed Type: SNF/NF: 54 SNF: 4 Total: 58 Census Payor Type: Medicare: 4 Medicaid: 40 Other: 14 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/27/23.	F 0000	=""> p=""> =""> p=""> =""> p=""> Please accept the attached plan of correction as credible allegation of compliance to the deficiencies cited during this inspection. I would like to formally request your consideration for granting this facility paper compliance. Pilgrim Manor submits this plan of correction (POC) in accordance with specific regulatory requirements. The submission of the POC does not indicate an admission by Pilgrim Manor that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Pilgrim Manor. If after reviewing our plan of correction you have any questions or require additional information, please do not hesitate to contact myself, Lori A. Smith, Administrator at 574-936-9943.	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Smith	Administrator	03/17/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview and record review, the facility failed to follow care plans for range of motion for 2 of 23 residents whose care plans were reviewed. (Residents B and 12) Finding includes: 1. During an interview, on 2/8/2023 at 2:41 P.M., Resident B indicated the staff do range of motion when they put her hand splints on. A clinical record review was completed on 2/10/2023 at 3:49 P.M. Resident B's diagnoses included, but were not limited to: arthritis, osteoporosis, Parkinson's disease, malnutrition, dysphagia, and Barretts esophagus. A Significant Change MDS (Minimum Data Set) Assessment, dated 12/2/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 cognition intact. She required extensive assist of 2 staff for bed mobility, transfers, dressing, total assist for toilet use and supervision for eating. Ambulation activity itself did not occur during the entire period. Had impaired range of motion to both upper and lower extremities. A current care plan, dated 9/16/2022, indicated the resident had the potential for decreased ability to move related to weakness, discomfort and pain. Interventions included, but were not limited to: Gentle passive ROM (range of motion) to all 4 extremities 10 reps x 2 (or until her tolerance), ROM every morning and afternoon. Review handout with pictures and instructions left in residents room. Nurses: perform passive ROM	F 0656	1. Resident B and Resident 12 were not affected by this alleged deficient practice. Resident #B's care plan has been reviewed and updated (See Exhibit 1). Resident #12 was reviewed and her ROM has been discounted due to her refusal to participate. 2. Fourteen (14)) residents, not counting Resident B & Resident 12, had the potential to be affected by this alleged deficient practice. All of their care plans have been reviewed and updated if needed. (See Exhibit 2). 3. A new restorative plan has been developed and policy updated (See Exhibit 3). The MDS Coordinator, LPN, will oversee the program. There are now restorative binders at each unit. These will be completed by the person completing the restorative plan, per the care plan. It will include the date, minutes and any comments that may be made. The MDS Coordinator will change the care plans, each week, per any changes that may be needed. 4. Nursing staff were in-service on 3-14-23 thru 3-16-23 (See Exhibit 4). The MDS Coordinator will audit weekly the participation of the residents, documentation and make changes to the care plan as needed (See Exhibit 5).	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	exercises 2 x/day and encourage participation and praise for effort. Administer pain meds as needed. Consult with provider as needed. A January TAR (Treatment Administration Record) included an order with the entry date of 9/16/2022 for Nursing Restorative: Gentle Passive Range of Motion all four extremities 10 reps X 2 (or to her tolerance) am and pm. Resident B received the ROM 20 times out of 40 times the entire month. A February TAR included an order with the entry date of 9/16/2022 for Nursing Restorative: Gentle Passive Range of Motion all four extremities 10 reps X 2 (or to her tolerance) am and pm. Resident B received the ROM 5 times from 2/1/2023 through 2/14/2023. During an interview, on 2/15/2023 at 3:28 P.M. CNA 17 indicated Resident B did not have a restorative program and no active ROM. 2. During an interview, on 2/8/2023 at 10:55 A.M., Resident 12 indicated she had fallen and was not walking and wanted to. A clinical record review was completed on 2/13/2023 at 6:48 A.M. Resident 12's diagnoses included, but were not limited to: heart failure, hypertension, anxiety, and bipolar. A Quarterly MDS (Minimum Data Set), dated 11/25/2022, indicated she had a BIMS (Brief Interview for Mental Status) score of 15, cognitive intact. Required extensive staff assist of 1 staff for bed mobility, transfers, dressing, toilet use and supervision for eating. A current care plan, dated 8/17/2022, indicated the		The audit will continue weekly for 6 to 12 months. The audit will be reviewed at the weekly QA meeting (See Exhibit 6). The restorative plan and participation will be monitored by the quarterly QAPI committee. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers (2), MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical Director has reviewed this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident had the potential for decreased mobility related to weakness. Will participate in nursing restorative Active ROM (range of motion) exercises twice a day. Interventions included, but were not limited to: Both legs using 2 lb. weights, encourage participation in exercises, set up coach and cue resident to complete AROM twice a day. A current care plan, dated 8/17/2022, indicated the resident had the potential for decreased ability to move related to weakness and pain/discomfort. Goal was the resident will participate in nursing restorative walking program twice a day with goal of 60 feet twice a day. Interventions included, but were not limited to: Monitor and help cna's with walking program, teach resident the importance of doing exercise, and praise and encourage participation. Walk in hallway twice a day. A TAR (Treatment Administration Record) dated January 2023, indicated Resident 12 received AROM 8 times from January 1 to January 31, 2023, and lacked the documentation to show when she had been ambulated in the month of January. A TAR dated February 1st through the 15th, lacked the documentation to show when the resident received AROM and or was ambulated. During an interview, on 2/15/2023 at 2:14 P.M., CNA 17 indicated Resident 12 had an order for the range of motion and restorative walking and was on the care plan also. She indicated the Resident had not been walked. On 2/15/2023 at 10:22 A.M., the Administrator provided the policy titled," Interdisciplinary Care Plan", dated 3/24/2020. The policy indicated..." This facility maintains written plans of care. Plan of cares will be written in layman's language (7th			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	grade level). Contents of the individualized care plan will be: 1. To assist the interdisciplinary team, resident, resident's family or resident representative in developing quantifiable objectives for the highest level of functioning the resident may be expected to attain. 2. To be utilized as one communication tool between disciplines and staff members. 3. To document the resident's progress or status toward established objectives. 4. To guide All Departments in Safety Issues... Additionally, information from the care plan is disseminated to staff members responsible for carrying out the plan...." 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review, observation and interview, the facility failed to follow Physician's Orders for administration of morphine for 1 of 1 residents reviewed for pain management. (Resident 52) Finding includes: During an interview, on 2/9/2023 at 12:13 P.M., the daughter of Resident 52 indicated she has pain all the time.	F 0684	1. Resident #52 was not affected by this alleged deficient practice. On 2-24-23 resident #52 received an order for fentanyl patch 25 mcg per hour to help control pain (See Exhibit 7). 2. Three (3) other residents were identified on PRN morphine and had the potential to be affected by this alleged deficient practice. Their morphine orders have been updated to include	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A clinical record review was completed on 2/14/2023 at 11:13 A.M. Resident 52's diagnose included, but were not limited to: hypertension, hypothyroidism, dementia and depression. A Quarterly MDS (Minimum Data Set) Assessment, dated 1/10/2023, indicated Resident 52 had a BIMS (Brief Interview of Mental Status) score of 6, severely cognitive impaired. Required extensive assist of 2 staff for bed mobility, total assist of 2 staff for transfers, extensive of 1 staff for dressing, and total assist of 1 staff for eating and bathing. Received antidepressant and opiod medications. Current physician orders for Resident 52 included, acetaminophen suppository 650 mg (milligrams) every 6 hours PRN (as needed) for pain or fever. Muscle rub liniment-10-15 % topically to back twice a day for pain. Hydrocodone/Acetaminophen 5/325 mg 1 tablet twice a day at 8 A.M. and 8 P.M. for moderate to moderately severe pain, and Morphine 20 mg/ml give 5 mg every 8 hours as needed for severe pain. A current care plan, dated 1/11/2023, indicated the resident had the potential for pain related to complaints of pain. Intervention included, but were not limited to: asses physical symptoms and assess complaints of pain, use scale of 1-10, try non drug approach before giving pain med, back rub, offer activity, food or fluids. The February MAR (Medication Administration Record) indicated Resident 52 received Morphine on the following dates: 2/6/2023 at 2:18 A.M., with no pain assessment documented. 2/7/2023 at 7:11 P.M. with a documented pain		parameters for the level of pain (See Exhibit 8). None were affected by this alleged deficient practice. 3. All morphine will have parameters on when the medication shall be administered. All nurses have been in-serviced (See Exhibit 4) on pain assessments, pain management, following physician orders and following the pain assessment and management policy (See Exhibit 9-A & 9-B). 4. All residents on morphine will be audited daily, 5 days per week for 6 weeks. Then 3 days per week for 6 weeks and then weekly for 12 weeks (See Exhibit 10). This will be monitored in our Weekly QA meetings (See Exhibit 6). This will continue to be monitored in our monthly (See Exhibit 11) and quarterly QAPI meetings until committee has determined that substantial compliance has been achieved, at least 6 to 12 months. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers (2), MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scale of 5--moderate. 2/11/2023 at 3:03 A.M. with a documented pain scale 6--moderate. 2/12/2023 at 11:55 P.M. with a documented pain scale of 6--moderate. On 2/15/2023 at 10:25 A.M., the Administrator provided the policy titled, "Pain Assessment and Management", dated 5/8/2015, and indicated the policy is the one currently use by the facility. The policy indicated"... e. If the resident is not able to rate their pain, their nurse will use the USA pain rating scale to assess the residents pain. After completing the pain assessment based on th total score the pain level will be determined and the appropriate medication will be administered. 4. After rating the pain the following will be used to determine the pain level with the corresponding number: Residents able to verbal or use face scale: Mild pain -- level 1-3. Moderate pain --Level 4-6. Severe pain --Level 7-10... 6. Document the Level of Pain which the resident is experiencing, using a 1 to 10 scale (1 being the least, and 10 being the most pain) for residents able to assess pain or use the 0-14+ scale for residents unable to assess pain, along with the reason for administration and the resident's response to the medication. Document other non-medication interventions tried before medication given...." During an interview, on 2/15/2023 at 3:15 P.M., the Director of Nursing indicated that they did not follow the pain scale for the medication administration and should have tried the other medications before the Morphine. 3.1-37		Director reviewed this POC.	
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure physician orders and care plan interventions for pressure ulcer were followed for 1 of 4 residents reviewed for pressure ulcers. (Residents B) Finding includes: During an interview, on 2/8/2023 at 2:41 P.M., Resident B indicated "she had an area to her bottom and the staff put salve on it." A clinical record review was completed, on 2/10/2023 at 3:49 P.M. Resident B's diagnoses included, but were not limited to: arthritis, osteoporosis, Parkinson's disease, malnutrition and Barrettes esophagus. A Significant Change MDS (Minimum Data Set) Assessment, dated 9/12/2022, indicated Resident B's had had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. She required extensive assist of 2 staff for bed mobility, transfers, dressing, total assist for toilet	F 0686	1. Resident B had the potential to be affected by this alleged deficient practice. Resident B and her daughter do not want a roho cushion, due to resident B doesn't like it. The roho has been discontinued. The care plan has been updated and changed to a gel cushion (See exhibit 12). The order for booties was changed, per resident B request, to only be worn when in bed, this was changed on 2-22-23 (See exhibit 12). Turn schedules, that are not routine, every two hours, now have a green bed visual aid on the wall by the light. Resident B is on a specialized turn schedule and has a fluorescent green bed on the wall. See pressure ulcer treatment policy (See Exhibit 13). This has the turn schedule for resident B to only be on her left side or supine. Resident B	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	use and supervision for eating. Had an unhealed stage III pressure ulcer. A Significant Change MDS (Minimum Data Set) Assessment, dated 12/2/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15, cognition intact. She required extensive assist of 2 staff for bed mobility, dressing, total assist for transfers, toilet use and eating. Had an unstageable pressure ulcer. Resident B's current Physician Orders included: 2/2/2023 Check placement of boots on both feet, every shift NOC (night) AM and PM. A current care plan, dated 09/7/2022, and updated on 11/1/2022, indicated the resident was at risk for broken or damaged skin, related to limited ability to move around, had an unstageable pressure ulcer on her sacrum. Interventions included, but were not limited to: weekly skin check, teach resident to shift weight in wheelchair. Nutritional supplements as ordered. Check every shift for gel cushion in wheelchair. Check areas related to knee abductor and palm protectors for pressure. Ensure placement of knee abductor, palm protectors and boot eve shift. Keep heels elevated off bed, reposition hourly when in recliner and do not turn on right side. Use a wedge when turning and follow turning schedule. Roho (pressure relieving cushion) to wheel chair and move cushion to what ever chair she in sitting in. During an observation, on 2/13/2023 at 5:28 A.M., Resident B was lying in bed on her left side with no boots on. One (1) blue spongy boot was observed on the another bed in the room.		pressure ulcer is healed as of 2-28-23. 2. An audit was conducted for all residents with pressure ulcers. There is one (1) resident with a pressure ulcer. Care plans and physician orders have been reviewed. Resident has pressure relieving wheelchair cushions and turn schedule in place (See Exhibit 14). 3. All residents with pressure ulcers will be reviewed to ensure preventative measures are in place, i.e. booties, turn schedules, pressure relieving cushions, etc. New interventions may be implemented. Nursing staff have been in-serviced on physician orders, following care plan and pressure ulcer prevention policy (See Exhibit 4). 4. All residents with pressure ulcers will be audited daily, 5 days per week for 6 weeks. Then 3 days per week for 6 weeks and then weekly for 12 weeks (See Exhibit 15). This will be monitored in our Weekly QA meetings (See Exhibit 6). This will continue to be monitored in our monthly (See Exhibit 11) and quarterly QAPI meetings until committee has determined that substantial compliance has been achieved, at least 6 to 12 months. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation, on 2/13/2023 at 7:45 A.M., Resident B was lying on her back in bed with no boots on. The Roho cushion was not observed in the wheel chair. During an observation of wound care, on 2/13/2023 at 9:00 A.M., RN 5 complete the dressing change to the wound on the residents sacral area. Observed a quarter size open red area with the skin off and other smaller areas of a light brownish color, with a darker brown color to the surrounding area. No odor or drainage observed. No pain noted from the resident. RN 5 indicated the area was unstageable and had the area for a long time. During an observation, on 2/14/2023 at 2:22 P.M., observed Resident B sitting in her recliner with no Roho cushion, and 2 blue spongy booties laying on her bed. Resident B indicated, "they found another bootie." During an observation, on 2/15/2023 at 3:28 P.M., with CNA 17, Resident B was sitting in the recliner with no Roho cushion and was positioned on her right side. During an interview, on 2/15/2023 at 3:29 P.M., CNA 17 indicated the resident should not be on her right side. Stated they even had a turn/position change schedule on the wall above her bed, and there should have been a Roho cushion on the chair. On 2/15/2023 a policy was requested for Pressure Ulcer Prevention, but one was not provided. On 2/15/2023 at 10:25 A.M., the Administrator provided the policy titled,"Pressure Ulcer Risk Assessment." dated 2/22/2022. The policy		(2), MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical Director has reviewed this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated"...5. Appropriate nursing interventions are initiated and outlined on the resident's Care Plan based on each resident's risk rating (Moderate Risk, High Risk or Severe Risk).... This Federal tag relates to Compliant IN00397354 3.1-40			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review, observations, and interview, the facility failed to ensure a resident who is fed by a tube, receive the physicians' ordered tube feeding to maintain her weight for 1 of 3 residents reviewed for nutrition. (Resident B)	F 0692	1. Resident B's continuous 12 hour feed has been changed to 1080 ml, per Dietician's recommendation. This will run continuously for 12 hours or until 1080 ml is reached (See Exhibit	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Finding includes: During an interview, on 2/08/2023 at 2:38 P.M., Resident B indicated she had lost 20 Lbs and the staff do her feeding three times a day. Observed the feeding pump not currently running. A clinical record review was completed on 2/10/2023 at 3:49 P.M. Resident B's diagnoses included, but were not limited to: arthritis, osteoporosis, Parkinson's disease, malnutrition, dysphagia, and Barretts esophagus. A Significant Change MDS (Minimum Data Set) Assessment, dated 12/2/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 cognition intact. She required extensive assist of 2 staff for bed mobility, transfers, dressing, total assist for toilet use and supervision for eating. Weight was 100. Resident B's current Physician Orders included: Osmolite 1.2 x 12 hours on at 9 P.M. and off at 9 A.M., run at 80 ml (milliliters) per hour. During an observation, on 2/13/2023 at 4:30 A.M., the tube feeding was running at 80 ml hour with the number of 530 on the pump, indicating the amount infused. During an observation, on 2/13/2023 at 5:17 A.M.,the tube feeding was running at 80 ml hour with the number of 591 on the pump, indicating the amount infused. During an observation, on 2/13/2023 at 6:15 A.M., the tube feeding was running at 80 ml hour with the number of 666 on the pump, indicating the amount infused.		16). Flushes were changed to not be done during the 12 hour continuous feed; therefore the continuous feed will not be interrupted. She is on weekly weights and her weight is 100.6 as of 3-14-23, she is a 5.1% gain in 30 days. 2. No other residents are on tube feeding; therefore, no one was affected. 3. On 2-17-23 nurses were in-serviced on continuous feed to run until 1000 ml has been completed. In-serviced that the feed is to not be turned off until it reaches 1000 ml (See Exhibit 17). Gastrostomy Tube Feedings Policy has been updated (See Exhibit 18). 4. All residents with feeding tubes will be audited daily, 7 days per week for 6 weeks. Then 5 days per week for 6 weeks and then 3 days per week for 12 weeks (See Exhibit 19). This will be monitored in our Weekly QA meetings (See Exhibit 6). This will continue to be monitored in our monthly (See Exhibit 11) and quarterly QAPI meetings until committee has determined that substantial compliance has been achieved, at least 6 to 12 months. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers (2), MDS Coordinator, Infection Prevention Nurse, Medical	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation, on 2/13/2023 at 7:21 A.M., the tube feeding was running at 80 ml hour with the number of 720 on the pump, indicating the amount infused. During an observation, on 2/13/2024 at 9:15 A.M., RN 6 administered medications to Resident B. RN 6 turned off the feeding, flushed the tube, administered the medications, flushed the tube and then hooked up the feeding tube to the machine and turned it on at 80 ml an hour. During an interview, on 2/13/2023 at 9:25 A.M., RN 6 indicated she was unsure when the feeding had been started but would find out. On 2/13/2023 at 9:30 A.M., RN 6 indicated the feeding was started at 9:30 P.M. and had just turned it off at 9:33 A.M. The Medication Administration Record, dated January 1st to January 31st indicated the tube feeding start and stop times were documented as: 1/1/23 on at 9:17 P.M. off at 9:00 A.M. running at 70 ml per hour 1/2/23 on at 9:51 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/4/23 on at 9:43 P.M. of at 9:00 A.M. running at 70 ml per hour. 1/5/23 on at 9:25 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/6/23 on at 9:45 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/8/23 no time when started was documented. 1/9/23 on at 9:39 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/11/23 on at 9:33 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/12/23 on at 9:43 P.M. off at 9:00 A.M. running at 70 ml per hour.		Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical Director has reviewed this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/13/23 on at 9:41 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/14/23 on at 9:30 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/16/23 on at 9:45 P.M. off at 9:00 A.M. running at 70 ml per hour. A Physician's Order, dated 1/17/20223 indicated to run the tube feeding at 75 ml per hour on at 9:00 P.M. and off at 9:00 A.M. 1/17/23 on at 10:08 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/19/23 on at 9:45 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/20/23 on at 9:29 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/21/23 on at 9:42 P.M. off at 7:37 A.M. running at 75 ml per hour. 1/24/23 on at 9:45 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/25/23 on at 9:27 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/26/23 on at 9:21 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/27/23 no documentation of start time and or stop time. A Physician's Order, dated 1/27/2023, indicated to run the tube feeding at 45 ml per hour on at 9:00 P.M. and off at 9:00 A.M. 1/28/23 on at 9:55 P.M. off at 9:00 A.M. running at 45 ml hour. 1/29/23 on at 9:39 P.M. off at 9:00 A.M. running at 45 ml hour. 1/30/23 on at 9:43 P.M. off at 9:00 A.M. running at 45 ml hour. 1/31/23 on at 9:34 P.M. off at 9:00 A.M. running at 45 ml hour.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident B did not receive 922.68 ml of her tube feedings from 1/2/2023 to 1/31/2023. A Physician's Order, dated 2/1/2023, indicated to run the tube feeding at 75 ml per hour on at 9:00 P.M. off at 9:00 A.M. The Medication Administration Record, dated February 1 to February 15 indicated the tube feeding start and stop times were documented as: 2/1/23 on at 9:45 P.M. off at 9:00 A.M. running at 75 ml hour. 2/2/23 on at 9:36 P.M. off at 9:00 A.M. running at 75 ml hour. A Physician's Order, dated 2/3/2023, indicated to run the tube feeding at 80 ml per hour on at 9:00 P.M. and off at 9:00 A.M. 2/3/23 on at 9:18 P.M. off at 9:00 A.M. running at 80 ml hour. 2/8/23 on at 9:25 P.M. off at 9:00 A.M. running at 80 ml hour. 2/9/23 no documentation of a start time. Running at 80 ml hour. 2/10/23 on at 9:41 P.M. off at 9:00 A.M. running at 80 ml hour. 2/11/23 on at 9:26 P.M. off at 9:00 A.M. running at 80 ml hour. 2/12/23 on at 9:30 P.M. off at 9:30 A.M. running at 80 ml hour. 2/13/23 on at 9:45 P.M. off at 9:00 A.M. running at 80 ml hour. 2/14/23 on at 9:33 P.M. off at 9:00 A.M. running at 80 ml hour. A Physician's Order, dated 2/7/2023, indicated to give a bolus of 250 ml of Osmolite 1.2 ml three times a day at 12:00 P.M., 3:00 P.M., and 6:00 P.M.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Must be up at 60 degree angle during the bolus and 1 hour after. Resident B did not receive 393.75 ml of her tube feedings from 2/1/2023 to 2/14/2023. A current care plan, dated 9/7/2022, indicated the resident had a feeding tube in place. Goal for the resident to tolerate the tube feeding with no vomiting/diarrhea. Interventions included nothing by mouth, Osmolite 1.2 at 80 ml/hour continuously from 9:00 P.M. to 9:00 A.M. A current care plan, dated 9/15/2022, indicated the resident had a tube feeding. Goal was for no evidence of weight loss and no chocking episodes. Interventions included, but were not limited to: monitor weights, abdominal assessment as needed, and give feedings as ordered. Resident B's weights from 10/2023 to 2/8/20223: On 10/4/2022 it was 94. On 11/2/2022 it was 95.2. On 12/2/2022 it was 99.8. On 1/4/2023 it was 100.4 On 2/2/2023 it was 94.8. On 2/8/2023 it was 94.4 Resident B had a significant weight loss of 5.6 Lbs from 1/4/2023 to 2/2/20232 which equaled a 5.58 % total body weight loss. A Nurse Note, dated 2/3/2023, indicated the physician had been notified of the significant weight loss and received a new order to increase the tube feeding to 80 ml an hour. During an interview, on 2/15/2023 at 10:34 A.M., the Director of Nursing indicated the tube feedings should have been turned on at 9:00 P.M.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and they were not. On 2/145/2023 at 10:25 A.M. the Administrator provided the policy titled,"Gastrostomy Tube Feedings", dated 11/14/2019, and indicated the policy was the one currently used by the facility. The policy indicated"...2. For Continuous Feeding: a. Type and rate of feeding established by physician order and administered via feeding pump with appropriate tubing/bag set...c. Follow manufacturer's instructions as to length of time feeding can hand unrefrigerated...." This Federal tag relates to Complaint IN00397354. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on record review, observation and interview, the facility failed to provide the appropriate amount of enteral formula to prevent adverse complications of weight loss for 1 of 1 residents reviewed for enteral feeding. (Resident B) Finding includes: During an interview, on 2/08/2023 at 2:38 P.M., Resident B indicated they do the feeding three times a day. Observed the feeding pump not currently running. A clinical record review was completed on 2/10/2023 at 3:49 P.M. Resident B's diagnoses included, but were not limited to: arthritis, osteoporosis, Parkinson's disease, malnutrition, dysphagia, and Barretts esophagus. A Significant Change MDS (Minimum Data Set) Assessment, dated 12/2/2022, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 15 cognition intact. She required extensive assist of 2 staff for bed mobility, transfers, dressing, total assist for toilet use and supervision for eating. Weight was 100. Resident B's current Physician Orders included: Osmolite 1.2 x 12 hours on at 9 P.M. and off at 9 A.M., run at 80 ml (milliliters) per hour. During an observation, on 2/13/2023 at 4:30 A.M., the tube feeding was running at 80 ml hour with the number of 530 on the pump, indicating the amount infused. During an observation, on 2/13/2023 at 5:17	F 0693	1. Resident B's continuous 12 hour feed has been changed to 1080 ml, per Dietician's recommendation. This will run continuously for 12 hours or until 1080 ml is reached (See Exhibit 16). Flushes were changed to not be done during the 12 hour continuous feed; therefore the continuous feed will not be interrupted. She is on weekly weights and her weight is 100.6 as of 3-14-23, she is a 5.1% gain in 30 days. 2. No other residents are on tube feeding; therefore, no one was affected. 3. On 2-17-23 nurses were in-serviced on continuous feed to run until 1000 ml has been completed. In-serviced that the feed is to not be turned off until it reaches 1000 ml (See Exhibit 17). Gastrostomy Tube Feedings Policy has been updated (See Exhibit 18). 4. All residents with feeding tubes will be audited daily, 7 days per week for 6 weeks. Then 5 days per week for 6 weeks and then 3 days per week for 12 weeks (See Exhibit 19). This will be monitored in our Weekly QA meetings (See Exhibit 6). This will continue to be monitored in our monthly (See Exhibit 11) and quarterly QAPI meetings until committee has determined that	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A.M.,the tube feeding was running at 80 ml hour with the number of 591 on the pump, indicating the amount infused. During an observation, on 2/13/2023 at 6:15 A.M., the tube feeding was running at 80 ml hour with the number of 666 on the pump, indicating the amount infused. During an observation, on 2/13/2023 at 7:21 A.M., the tube feeding was running at 80 ml hour with the number of 720 on the pump, indicating the amount infused. During an observation, on 2/13/2024 at 9:15 A.M., RN 6 administered medications to Resident B. RN 6 turned off the feeding, flushed the tube, administered the medications, flushed the tube and then hooked up the feeding tube to the machine and turned it on at 80 ml an hour. During an interview, on 2/13/2023 at 9:25 A.M., RN 6 indicated she was unsure when the feeding had been started but would find out. On 2/13/2023 at 9:30 A.M., RN 6 indicated the feeding was started at 9:30 P.M. and had just turned it off at 9:33 A.M. The Medication Administration Record, dated January 1st to January 31st indicated the tube feeding start and stop times were documented as: 1/1/23 on at 9:17 P.M. off at 9:00 A.M. running at 70 ml per hour 1/2/23 on at 9:51 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/4/23 on at 9:43 P.M. of at 9:00 A.M. running at 70 ml per hour. 1/5/23 on at 9:25 P.M. off at 9:00 A.M. running at 70 ml per hour.		substantial compliance has been achieved, at least 6 to 12 months. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers (2), MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical Director has reviewed this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/6/23 on at 9:45 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/8/23 no time when started was documented. 1/9/23 on at 9:39 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/11/23 on at 9:33 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/12/23 on at 9:43 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/13/23 on at 9:41 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/14/23 on at 9:30 P.M. off at 9:00 A.M. running at 70 ml per hour. 1/16/23 on at 9:45 P.M. off at 9:00 A.M. running at 70 ml per hour. A Physician's Order, dated 1/17/20223 indicated to run the tube feeding at 75 ml per hour on at 9:00 P.M. and off at 9:00 A.M. 1/17/23 on at 10:08 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/19/23 on at 9:45 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/20/23 on at 9:29 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/21/23 on at 9:42 P.M. off at 7:37 A.M. running at 75 ml per hour. 1/24/23 on at 9:45 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/25/23 on at 9:27 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/26/23 on at 9:21 P.M. off at 9:00 A.M. running at 75 ml per hour. 1/27/23 no documentation of start time and or stop time. A Physician's Order, dated 1/27/2023, indicated to run the tube feeding at 45 ml per hour on at 9:00 P.M. and off at 9:00 A.M.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/28/23 on at 9:55 P.M. off at 9:00 A.M. running at 45 ml hour. 1/29/23 on at 9:39 P.M. off at 9:00 A.M. running at 45 ml hour. 1/30/23 on at 9:43 P.M. off at 9:00 A.M. running at 45 ml hour. 1/31/23 on at 9:34 P.M. off at 9:00 A.M. running at 45 ml hour. The Medication Administration Record, dated February 1 to February 15 indicated the tube feeding start and stop times were documented as: A Physician's Order, dated 2/1/2023, indicated to run the tube feeding at 75 ml per hour on at 9:00 P.M. off at 9:00 A.M. 2/1/23 on at 9:45 P.M. off at 9:00 A.M. running at 75 ml hour. 2/2/23 on at 9:36 P.M. off at 9:00 A.M. running at 75 ml hour. A Physician's Order, dated 2/3/2023, indicated to run the tube feeding at 80 ml per hour on at 9:00 P.M. and off at 9:00 A.M. 2/3/23 on at 9:18 P.M. off at 9:00 A.M. running at 80 ml hour. 2/8/23 on at 9:25 P.M. off at 9:00 A.M. running at 80 ml hour. 2/9/23 no documentation of a start time. Running at 80 ml hour. 2/10/23 on at 9:41 P.M. off at 9:00 A.M. running at 80 ml hour. 2/11/23 on at 9:26 P.M. off at 9:00 A.M. running at 80 ml hour. 2/12/23 on at 9:30 P.M. off at 9:30 A.M. running at 80 ml hour. 2/13/23 on at 9:45 P.M. off at 9:00 A.M. running at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	80 ml hour. 2/14/23 on at 9:33 P.M. off at 9:00 A.M. running at 80 ml hour. A current care plan, dated 9/15/2022, indicated the resident had a tube feeding. Goal was for no evidence of weight loss and no chocking episodes. Interventions included, but were not limited to: monitor weights, abdominal assessment as needed, and give feedings as ordered. A current care plan, dated 9/7/2022, indicated the resident had a feeding tube in place. Goal for the resident to tolerate the tube feeding with no vomiting/diarrhea. Interventions included nothing by mouth, Osmolite 1.2 at 80 ml/hour continuously from 9:00 P.M. to 9:00 A.M. Resident B's weights from 10/2023 to 2/8/20223: On 10/4/2022 it was 94. On 11/2/2022 it was 95.2. On 12/2/2022 it was 99.8. On 1/4/2023 it was 100.4 On 2/2/2023 it was 94.8. On 2/8/2023 it was 94.4 Resident B had a significant weight loss of 5.6 Lbs from 1/4/2023 to 2/2/20232 which equaled a 5.58 % total body weight loss. During an interview, on 2/15/2023 at 10:34 A.M., the Director of Nursing indicated the tube feedings should have been turned on at 9:00 P.M. and they were not. On 2/145/2023 at 10:25 A.M. the Administrator provided the policy titled,"Gastrostomy Tube Feedings", dated 11/14/2019, and indicated the policy was the one currently used by the facility. The policy indicated"...2. For Continuous			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Feeding: a. Type and rate of feeding established by physician order and administered via feeding pump with appropriate tubing/bag set...c. Follow manufacturer's instructions as to length of time feeding can hand unrefrigerated...." This Federal tag relates to Complaint IN00397354. 3.1-44(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observations, interviews, and record review, the facility failed to adequately monitor side effects and behaviors for 3 out of 5 residents that took psychotropic medications (Residents 3, 40, and 50.) Findings include: 1. During an observation on 2/08/2023 11:33 A.M., Resident 3 was noted to have severe tongue thrust when speaking and at rest. A clinical record review on 2/13/2023 at 10:35 A.M., indicated Resident 3's diagnoses included, but were not limited to, schizoaffective disorder, bipolar type; Alzheimer's; general anxiety disorder; drug induced subacute dyskinesia; extra pyramidal movement; and depression. A Quarterly MDS (Minimum Data Set)	F 0758	1. Residents #3, 40 and 50 were not affected by this alleged deficient practice. Resident #40 & #50 care plans have been updated to reflect monitoring of psychotropics side effects and behaviors, daily & PRN (See Exhibit 20). Resident #3 has been on psychotropic medications since a teenager. He has Tardive Dyskinesia. His side effect/behavior monitoring has been changed to monitor for signs and symptoms worsening, on a daily basis. His care plan has been changed to reflect daily monitoring of worsening signs and symptoms. (See Exhibit 21). 2. There are 30 residents that are on psychotropic medications.	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Assessment dated 1/20/2023 for Resident 3 included, but was not limited to, a BIMS (Brief Interview for Mental Status) of 14 which indicated no impairment. Mood concerns indicated feeling bad about himself 7 out of 11 days, trouble concentrating 6 out of 10 days, and fidgeting 7 out of 11 days. He was independent for all activities of daily living. Active diagnoses were non-traumatic brain dysfunction, Alzheimer's, depression, bipolar disorder, schizophrenia, and extra pyramidal movements. The medication section included antipsychotic, antidepressant, hypnotic, and he received an antipsychotic on a regular basis. A GDR (Gradual Dose Reduction) was last attempted on 9/19/2022. Physician orders for Resident 3 included, but were not limited to, fluoxetine 40 mg (milligram) on 4/11/2018; benztropine 1mg on 3/14/2022; Seroquel 100 mg, and 300 mg on 3/30/2022; austedo 12 mg on 12/1/2021; and lithium 300 mg. Resident 3's care plan indicated, but was not limited to, a problem, dated 2/12/2018, for a potential for disruptive interaction. Interventions included, but were not limited to, behavior tracking every shift, monitor for side effects, and meds as ordered. A problem, dated 1/25/2018, for potential for depression with interventions that included, but were not limited to, monitor for side effects and watch every shift for signs of depression/sadness. Medication administration records for Resident 3 indicated, but were not limited to, missing behavior monitoring for 7 shifts in January 2023, and 7 shifts between February 1 and 13, 2023. Monitoring for signs of depression was missing for 6 shifts in January 2023 and 7 shifts between February 1 and 13, 2023. Side effect monitoring		All their care plans have been reviewed and updated to reflect daily monitoring of signs and symptoms of the psychotropic medication. The policy has been updated to reflect psychotropics/behaviors will be monitored at least daily (See Exhibit 22). On the TAR all shifts will be able to document, in case of changes; however, the requirement is to be done at least daily. 3. The psychotropic policy has been updated (See Exhibit 22). The side effect/behavior charting will remain on the TAR for all 3 shifts. This will allow anyone who notices changes to document; however, the policy is that the side effect/behavior charting will be done at least daily. The TAR has been changed to reflect this. All nurse's have been in-serviced (See Exhibit 4) on monitoring and documenting psychotropic medications side effects/behaviors. 4. All residents that have psychotropic medications will be audited daily, 5 days per week for 6 weeks. Then 3 days per week for 6 weeks and then weekly for 12 weeks (See Exhibit 23). This will be monitored in our Weekly QA meetings (See Exhibit 6). This will continue to be monitored in our monthly (See Exhibit 11) and quarterly QAPI meetings until committee has determined that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was missing documentation for 6 shifts in January 2023 and 6 shifts between February 1 and 13, 2023. During an interview, on 2/14/2023 at 9:34 A.M., the unit manager indicated that they should be monitoring behaviors and side effects for Resident 3, but she wasn't sure how often. 2. A clinical record review for Resident 40, on 2/10/2023 at 11:04 A.M., indicated a Quarterly MDS dated 1/13/2023 included, but was not limited to, a BIMS of 15, which indicated no impairment; trouble falling or staying asleep 7-11 days, tired with little energy 2-6 days, and poor appetite or overeating 2-6 days; no behaviors were noted; limited assist of 1 staff member for bed mobility, transfers, dressing, eating, and toileting, independent for personal hygiene; Non-Alzheimer's dementia, and depression; scheduled pain meds, no falls; antidepressant 7 out of 7 days; and no psychotherapy. Resident 40's diagnoses included, but were not limited to, depression, unspecified, and anxiety disorder. Physician orders for Resident 40 included, but were not limited to, Cymbalta 20 mg. A GDR was done 11/29/2022. Resident 40's care plan included, but was not limited to, a problem dated 2/18/2019 for a potential for depression. Interventions included, but were not limited to, watch for signs of depression and monitor for signs of increased depression. Medication administration records for Resident 40 included, but were not limited to, missing behavior monitoring documentation for signs and		substantial compliance has been achieved, at least 6 to 12 months. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers (2), MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical Director has reviewed this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms of depression for 6 shifts in January 2023 and 7 shifts between February 1 and 13, 2023. Side effect monitoring documentation was missing for 6 shifts in January 2023 and 6 shifts between February 1 and 13, 2023. During an interview, on 2/14/2023 at 9:34 A.M., the unit manager indicated that they should be monitoring behaviors and side effects for Resident 40, but she wasn't sure how often. 3. During a clinical record review for Resident 50 done, on 2/14/2023 at 1:14 P.M., the Quarterly MDS, dated 1/17/2023, included, but was not limited to, BIMS of 15, which indicated no impairment; independent for all activities of daily living; active diagnoses of depression, bipolar disorder; antipsychotic on a routine basis, and antidepressant. Physician orders for Resident 50 included, but was not limited to, duloxetine 30 mg on 6/1/22 and Seroquel 25 mg on 1/27/2023. A care plan, dated 7/7/2022, for Resident 50 included, but was not limited to, a problem indicating a potential for disruptive interaction. An intervention included, but was not limited to, behavior tracking every shift. Another problem indicated a potential for depression. An intervention included, but was not limited to, watch for signs of depression. Medication administration records for Resident 50 included, but were not limited to, missing behavior monitoring documentation for 5 shifts in January 2023 and 4 shifts between February 1 and 13, 2023. Side effect monitoring was missing for 5 shifts in January 2023 and 9 shifts between February 1 and 13, 2023.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 2/14/2023 at 9:34 A.M., the unit manager indicated that they should be monitoring behaviors and side effects for Resident 50, but she wasn't sure how often. A policy provided by the DON (Director of Nursing), on 2/14/2023 at 10:03 A.M., titled, "Behavioral Monthly Meeting" and dated 5/1/2022, included, but was not limited to, "...An interdisciplinary team consisting of Nursing, Social Services, Administrator, Pharmacy, and NP psychiatric nurse, as she can, will meet monthly to review all of the previous monthly behavioral documentation...." A policy provided by the DON, on 2/14/2023 at 10:03 A.M., titled, " ...Antipsychotic Drugs," dated 4/1/2006, included, but was not limited to, " ...We will assure that residents who are undergoing antipsychotic drug therapy receive adequate monitoring, on a daily basis, for significant side effects of such therapy with emphasis on the following: Tardive dyskinesia, Postural (orthostatic) hypotension, Cognitive behavior impairment, Akathesia, and Parkinsonism ...." 3.1-48(a)(3)(5)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals 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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) 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. Based on observation and interview, the facility failed to ensure medication storage areas were free from medications with no resident identifiers, free from expired glucose control solutions, medications were dated when opened, and intravenous supplies did not remain in the facility after the resident had expired during medication storage reviews. (West Medication Cart, Central Medication Cart, and East Medication Room) Findings include: 1. During a medication storage review, on 2/14/2023 at 2:14 P.M., of the West medication cart with QMA 18, the following was observed: An opened bottle of turmeric (dietary supplement) unlabeled and an opened box of Even Care G2 glucose solution that had expired on 5/20/2022. During an interview, on 2/14/2023 at 2:18 P.M., QMA 17 indicated the turmeric should have been	F 0761	1. Resident #54 was not affected by this deficient practice. She did not receive the expired medication. 2. All residents have the potential to be affected by this alleged deficient practice. None were affected by this alleged deficient practice. 3. All Medication Storage Rooms and Medication carts have been audited and all expired medications, discharged resident pharmaceutical supplies, unlabeled medications, including glucose control solutions and intravenous supplies have been destroyed or returned to pharmacy. An in-service was held on 3-14-23 through 3-16-23 for all nurses. Policy Medication	03/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	labeled and the glucose control solution should not be in the cart. 2. During a medication storage review, on 2/14/2023 at 2:22 P.M., of the Central medication cart with QMA 15, the following was observed: An opened, undated when opened bottle of Morphine Sulfate (opioid) with an issue date of 10/19/2022 for Resident 54. The bottle had a label stating discard 90 days after opening. During an interview, on 2/14/2023 at 2:23 P.M., QMA 15 indicated the bottle should have had an opened dated and should have been thrown out. 3. During a medication storage review, on 2/24/2023 at 2:37 P.M., of the East medication room, with LPN 19, the following was observed: 4-6 bags of intravenous tubing's, filled syringes of saline, and IV dressing kits for a resident who does not currently reside in the facility. During an interview, on 2/14/2023 at 2:38 P.M., LPN 19 indicated the IV supplies should have been returned to the pharmacy. On 2/15/2023 at 10:23 A.M., the Administrator provided the policy titled,"Medication Labeling and Storage", dated 12/16/2016, and indicated the policy was the one currently used by the facility. The policy indicated"... I. Labeling of the Medication Container... F. Open dates on container of applicable... NOTE* If the medication is an over- the-counter medication which was not delivered by the pharmacy, a handwritten legible label with the resident's name and physician's name must be present...." On 2/15/2023 at 10:25 A.M., the Administrator provided the policy titled," Medication		Labeling and Storage (See Exhibit 24), and Medication Expiration policy (See Exhibit 25) will be followed. All nurses have been in-serviced (See Exhibit 4) on medication labeling and storage and medication expiration. 4. All Medication carts and Medication storage rooms will be audited daily, 5 days per week for 6 weeks. Then 3 days per week for 6 weeks and then weekly for 12 weeks (See Exhibit 26). This will be monitored in our Weekly QA meetings (See Exhibit 6). This will continue to be monitored in our monthly (See Exhibit 11) and quarterly QAPI meetings until committee has determined that substantial compliance has been achieved, at least 6 to 12 months. The Quarterly QAPI Committee consists of: Administrator, DON, Medical Director, Pharmacist, Social Services, Unit Managers (2), MDS Coordinator, Infection Prevention Nurse, Medical Records, Staff Development, Business Office Manager, Activity Director, Maintenance Director, Environmental Service Director, Dietary Manager and at least one floor staff personnel. The Medical Director has reviewed this POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155073	A. BUILDING 00 B. WING	02/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Disposition/Destruction", dated 6/11/2021, and indicated the policy was the one currently used by the facility. The policy indicated"... Purpose: 1. To dispose of all outdated or unwanted medications safely, legally and properly and/or treatments. 2. To ensure that controlled substances are not diverted... Process: * Return meds/treatments to {Name of Pharmacy} as per their policy...1. Non-Controlled Medications/Treatments: b. Any medications/or treatments that are no longer needed (i.e., have been discontinued) shall be destroyed on the premises...." 3.1-25(j) 3.1-25(n)			