STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195594	A. Building B. Wing	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pilgrim Manor Skilled Nursing and Rehabilitation	1524 Doctors Drive Bossier City, LA 71111

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interview, the facility failed to ensure a resident remained free from neglect when nursing staff failed to use a Hoyer lift to transfer 1 (Resident #F3) of 4 (Residents #F1, #F2, #F3, and #F4) sampled residents who required a mechanical lift for transfers.Findings:Review of the facility's Abuse and Neglect - Clinical Protocol policy with a revision date of 10/15/2025 revealed in part: Policy Statement: The facility will ensure that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility will provide a safe resident environment and protect residents from abuse. Definitions. Neglect, as defined by S483.5 as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of goods or services that a resident(s) requires but fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress. Neglect includes cases where the facility's indifference or disregard for resident care, comfort or safety, resulted in or could have resulted in physical harm, pain, mental anguish or emotional distress. Review of the facility's Lifting Machine, Using a Mechanical policy with a revision date of March 2025 revealed in part: The purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. General guidelines: 2. Mechanical lifts may be used for tasks that require: b. transferring a resident from bed to chair.Steps in the procedure: 1. Before using a lifting device, assess the resident's current transfer ability utilizing the [plan of care] located in the electronic health system. Review of the facility's Safe Lifting and Movement of Residents policy with a revision date of September 8, 2024 revealed in part: In order to protect the safety and well-being of staff and residents and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Policy Interpretation and Implementation1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.2. Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' needs for transfer assistance on admission, readmission, with MDS changes including IPA's, quarterly or significant change MDS and prn using the Therapy Screen Request 2.0 form. Staff will document resident transferring and lifting needs in the care plan. Such assessment shall include:b. Resident's mobility (degree of dependency);4. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Review of Resident #F3's medical record revealed an admit date of 03/03/2025 with diagnoses including in part peripheral vascular disease, spondylopathy of the lumbar area, vascular dementia and anxiety. Review of Resident #F3's quarterly MDS (Minimum Data Set) assessment dated [DATE] revealed in part, a BIMS (Brief Interview of Mental Status) score of 10 indicating moderately impaired cognition. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review revealed Resident #F3 was dependent upon staff for bed to wheelchair transfers. Review of Resident #F3's comprehensive care plan revealed in part, Resident #F3 was at risk for falls and was totally dependent on staff for transfers, with an intervention in place for the use of a Hoyer lift. Review of Resident #F3's Therapy Screen Request dated 09/11/2025 revealed Resident #F3 required total lift for transfers with a transfer plan to use a Hoyer lift. Review of Resident #F3's quarterly Lift Transfer Assessment dated 10/14/2025 revealed in part, Resident #F3's current level of assistance was total lift. Review of the facility's Lift Residents list with a revision date of 10/14/2025 revealed Resident #F3 was identified as requiring a Hoyer lift. An observation on 10/28/2025 at 8:00 a.m. revealed Resident #F3 sitting in a wheelchair in the dining room dressed in clean appropriate daytime clothing. Further observation failed to reveal a Hoyer lift pad was in place under Resident #F3. An Observation on 10/28/2025 at 8:30 a.m. revealed Resident #F3 sitting in wheelchair in therapy without a Hoyer lift pad in place. During an interview on 10/28/2025 at 8:30 a.m. Resident #F3 reported she did not remember who got her out of bed or how she got out of bed this morning and into the wheelchair. During an interview on 10/28/2025 at 8:35 a.m., SF2PTA (Physical Therapy Assistant) acknowledged Resident #F3 did not have a Hoyer lift pad beneath her in the wheelchair. SF2PTA indicated staff had not used the Hoyer lift to get Resident #F3 out of bed this morning and reported Hoyer lift pads were routinely kept under the resident while in a wheelchair in order to transfer resident back into bed. SF2PTA reported Resident #F3 required maximum assistance by staff for transfers. During an interview on 10/28/2025 at 8:50 a.m., SF3CNA (Certified Nursing Assistant) Supervisor, reported Resident #F3 had not been transferred out of bed this morning with the use of a Hoyer lift. SF3CNA Supervisor reported she observed the absence of a Hoyer lift pad in Resident #F3's wheelchair when she arrived to work this morning and stated she (Resident #F3) was not transferred right. SF3CNA Supervisor reported the night shift staff assigned to Resident #F3 was SF4Agency CNA. SF3CNA Supervisor acknowledged Resident #F3 was care planned for Hoyer lift transfers. SF3CNA Supervisor reported all nursing staff including agency staff should have been in-serviced on the correct use of a Hoyer lift and how to locate a resident's plan of care in the kiosk system. During an interview on 10/28/2025 at 9:00 a.m., SF5RN (Registered Nurse) Supervisor, reported staff did not follow the proper procedure when getting Resident #F3 out of bed this morning. SF5RN Supervisor reported she observed Resident #F3 seated in the dining room this morning without a lift pad in her wheelchair. SF5RN Supervisor reported the correct process for a Hoyer lift transfer included leaving the transfer pad under the resident once transferred into a wheelchair until the resident has been transferred back into bed. SF5RN Supervisor further reported once the resident has been transferred back into the bed by the Hoyer lift, the transfer pad would be removed. SF5RN Supervisor reported nursing staff and agency staff had been trained and in-serviced on the correct use of a Hoyer lift and how to locate a resident's plan of care in the kiosk system. SF5RN Supervisor acknowledged Resident #F3's current care plan indicated the use of a Hoyer lift for transfers. During a telephone interview on 10/28/2025 at 12:20 p.m., SF4Agency CNA confirmed she had worked the 10/27/2025 night shift which began at 7:00 p.m. and was assigned to Resident #F3. SF4Agency CNA confirmed she transferred Resident #F3 out of bed this morning, 10/28/2025, without the use of a Hoyer lift. SF4Agency CNA reported she did not use the Hoyer lift because Resident #F3 was able to help her with the transfer. SF4Agency CNA reported she knew how to use a Hoyer lift but used the stand and pivot transfer method she had learned in school to transfer Resident #F3 into her wheelchair. SF4Agency CNA reported she was trained by the facility on how to use the kiosk system to review a resident's plan of care and acknowledged Resident #F3 was care planned for the use of a Hoyer lift. SF4Agency CNA reported Resident #F3 did not have a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hoyer lift pad in her room and stated so I just transferred her (Resident #F3) the old school way. Review of S4Agency CNA's personnel record revealed an Agency CNA Facility Orientation acknowledgement dated and signed by SF4Agency CNA on 09/08/2025. Further review of SF4Agency CNA's Agency CNA Facility Orientation acknowledgement revealed the following responsibilities in part: - Locate Care Guide Care Guide and ____ in [kiosk]- Resident's plan of care is made by the team. The plan of care cannot be changed without or until the nurse or management has reassessed the resident. *As an agency staff member, I understand and acknowledge, it is my responsibility to provide quality of care consistent to the resident's needs. Any questions or concerns should be reported to the DON (Director of Nursing) or Administration. During an interview on 10/28/2025 at 3:00 p.m., SF6DOR (Director of Rehabilitation) reported she had assisted nursing staff with resident transfer assessments and recommendations for the need of Hoyer lifts. SF6DOR further reported the transfer recommendation for Resident #F3 remained as a Hoyer lift resident as indicated on the most recent 10/14/2025 facility list. SF6DOR acknowledged Resident #F3 had a status of total lift and CNAs should use a Hoyer lift with 2 staff assistance for total lift residents. During an interview on 10/28/2025 at 3:30 p.m., SF1Corporate Nurse acknowledged Resident #F3 required a Hoyer lift with 2 person assist for transfers and should have been transferred from the bed to the wheelchair with a Hoyer lift by SF4Agency CNA. [KH1]

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to use a Hoyer lift, as determined necessary by the resident's comprehensive care plan, during a transfer from the resident's bed to wheelchair for 1 (#1) of 3 (#1, #2, #3) sampled residents which resulted in a right humeral neck fracture.The deficient practice resulted in harm for Resident #1 on 07/14/2025 at approximately 10:30 a.m. when S6 agency CNA (Certified Nursing Assistant) transferred Resident #1 from the bed to a wheelchair with a stand and pivot method without utilization of a Hoyer lift. Resident #1 had an onset of acute pain to her right arm/shoulder and reported her right arm hit the wheelchair armrest during transfer. Resident #1 was care planned for activities of daily living self-care deficit with intervention of dependent in transferring with the use of Hoyer lift. S7 agency LPN (Licensed Practical Nurse), Hospice and Resident #1's Responsible Party were notified. Resident #1's right shoulder x-ray results dated 07/14/2025 revealed an acute complex impacted fracture involving the right humeral neck. Resident #1 was sent to the emergency room for further evaluation and treatment and returned to the facility with a right upper arm sling in place. Findings:Review of Resident #1's record revealed an admit date of 09/14/2023 with a re-admit on 12/13/2023 with diagnoses that included in part other sequelae of cerebral infarction, rheumatoid arthritis, generalized muscle weakness, muscle wasting and atrophy bilateral shoulders, and generalized osteoarthritis. Resident #1 was admitted to hospice for cerebral infarction on 12/16/2023 and passed away on 07/28/2025 in the facility.Review of Resident #1's Minimum Data Set assessment dated [DATE] revealed a Brief Mental Status of 8 which indicated moderately impaired cognition. Resident #1 had impaired functional range of motion in bilateral upper extremities and was dependent on staff for bed mobility and transfer.Review of Resident #1's Comprehensive Care Plan revealed the following problems with interventions: At risk for falls with intervention of transfer with Hoyer lift initiated on 11/23/2023.Activities of daily living self-care deficit with intervention of totally dependent in transferring with the use of Hoyer lift initiated on 01/01/2024. At risk for pain initiated 01/24/2024 with an update on 07/14/2025 for intervention right arm sling due to fracture of proximal end of right humerus.Review of the facility's Incident Report dated 07/14/2025 created by S7 agency LPN included in part S6 agency CNA was assisting Resident #1 into the wheelchair. Resident #1 reported during transfer she hit her right arm on the right wheelchair armrest and had an acute onset of pain rated 10 out of 10 to her right arm and more defined in right shoulder. Resident #1 was assessed and Resident #1 was able to move her hand but refused to perform range of motion to her right upper arm and shoulder due to pain. Resident #1's Hospice and Responsible Party were notified.Review of Resident #1's three view right shoulder x-ray results dated 07/14/2025 revealed an acute complex impacted fracture involving the right humeral neck.Review of Resident #1's Nurses Notes revealed in part Resident #1 was sent to the a local emergency room and returned to the facility the same day with a sling in place to her right arm.Review of the facilities training records revealed an Agency Facility Orientation sheet signed by S6 agency CNA on 04/14/2025. S6 agency CNA was oriented on locating CNA care guides including each resident's individual plan of care at CNA stations.Review of _____Staffing Agency records for staff in the facility July 2025 indicated S6 agency CNA worked at the facility on the following dates:07/01/2025; 07/05/2025; 07/06/2025; 07/08/2025; 07/13/2025; and 07/14/2025.During an interview on 08/26/2025 at 1:40 p.m. S8 agency CNA reported Resident #1 was able to make her needs known and was a two person assist with the Hoyer lift for transfers.During an interview on 08/26/2025 at 1:52 p.m. S9 LPN reported Resident #1 was able to make her needs known and was a two person assist with the Hoyer lift for transfers. S9 LPN reported a (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	list of resident's activities of daily living needs was kept at the nurses' station and if the resident required a Hoyer lift for transfer there would be a sign over the resident's bed. During a telephone interview on 08/27/2025 at 1:40 p.m. S7 agency LPN reported on 07/14/2025 S6 agency CNA transferred Resident #1 using a turn pivot method. S7 agency LPN reported residents who required the Hoyer lift for transfer had signs over their bed and Resident #1 did not on 07/14/2025. S7 agency LPN reported S6 agency CNA did not ask her about Resident #1's transfer abilities prior to using a turn pivot method. S7 agency LPN reported Resident #1 complained of shoulder pain and reported Resident #1 had bumped her arm on the wheelchair when transferring from the bed to the wheelchair. S7 agency LPN reported she notified Hospice and an x-ray was ordered. S7 agency LPN reported the x-ray indicated a fracture and Resident #1 was sent to the emergency room for further evaluation and treatment.During an attempted telephone interview on 08/27/2025 at 2:25 p.m. with S6 agency CNA there was no answer. Surveyor immediately received a call back from S6 agency CNA's telephone number. During this interview, S6 agency CNA reported she had worked agency throughout the facility wherever she was assigned. S6 agency CNA reported she had training at the facility, reported a resident's level of care could be checked in the computer, and if a resident required a Hoyer lift for transfer there would be a sign over the resident's bed. During interview on 08/27/2025 at 3:34 p.m. S3 DON reported Resident #1 had been on hospice for about 2 years, was able to make her needs known, and was a two person assist with the Hoyer lift for transfers. When asked about Resident #1's incident on 07/14/2025 S3 DON reported Resident #1 told her she hit her elbow on the arm of the wheelchair when the CNA transferred her to the wheelchair. S3 DON reported Resident #1 was assessed and indicated it appeared as though Resident #1's shoulder had possibly come out of socket. S3 DON reported Resident #1 reported pain and guarded her arm and shoulder. S3 DON reported Resident #1's Hospice and Responsible Party were notified and an x-ray was ordered. S3 DON reported the x-ray indicated a fracture and Resident #1 was sent to the emergency room and returned that evening with a sling in place to her arm. During a telephone interview with S11 agency CNA on 09/02/2025 at 8:18 a.m. S11 agency CNA reported she did not recall having cared for Resident #1. S11 agency CNA reported she learned of resident's transfer abilities from report or in the resident's chart. S11 agency CNA reported she recalled a resident being hurt during transfer. S11 agency CNA reported she recalled S6 agency CNA crying and telling her she had transferred a resident and did not know she was supposed to use the Hoyer lift. S11 agency CNA reported there was not a sign over the resident's bed.During an attempted phone interview with Resident #1's Responsible Party on 09/02/2025 at 9:13 a.m. there was no answer.During an interview on 09/02/2025 at 10:05 a.m. S12 agency LPN reported Resident #1 was not able to move on her own, and was not able to make her needs known all the time. S12 agency LPN reported when she provided care to Resident #1 there was a sign over her bed that indicated Resident #1 was transferred with a Hoyer lift.During an interview on 09/02/2025 at 10:45 a.m. S13 CNA reported Resident #1 was transferred with a Hoyer lift and had a sign over her bed that indicated Resident #1 was transferred with a Hoyer lift.During an attempted telephone interview with Resident #1's Responsible Party on 09/02/2025 at 12:59 p.m. there was no answer.During an interview on 09/02/2025 at 1:10 p.m. S3 DON and S4 ADON reported new staff and agency CNA staff were oriented to the facility, given access to the CNA charting record, and trained on how to locate things in a resident's CNA charting including transfer abilities prior to working. S3 DON and S4 ADON reported the agency CNAs sign on the Agency Facility Orientation sheet indicating they were oriented to the facility CNA charting system.During an interview on 09/02/2025 at 1:24 p.m. S1 Quality Improvement Nurse and S2 Quality Improvement Nurse confirmed new staff and agency CNA staff were oriented to the facility, given access to the CNA charting record, and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	trained on how to locate things in a resident's CNA charting including transfer abilities. S1 Quality Improvement Nurse and S2 Quality Improvement Nurse confirmed the agency CNAs sign on the Agency Facility Orientation sheet indicating they were oriented to the facility CNA charting system.During an interview on 09/02/2025 at 2:20 p.m. S5 ADON confirmed new staff and agency CNA staff were oriented to the facility, given access to the CNA charting record, and trained on how to locate things in a resident's CNA charting including transfer abilities prior to working. S5 ADON confirmed the agency CNAs sign on the Agency Facility Orientation sheet indicating they were oriented to the facility CNA charting system. S5 ADON reported she had scheduled staff for Resident #1's hall. S5 ADON reported on 07/14/2025 S6 agency CNA arrived late to the facility because she had to call the agency to cover staff due to a late call in. S5 ADON reported she was called to go with S3 DON when the incident with Resident #1 occurred on 07/14/2025. S5 ADON reported she was told Resident #1 was transferred using a lift and pivot method. S5 ADON reported she did not recall Resident #1's transfer abilities without reviewing Resident #1's record.During an interview on 09/03/2025 at 10:15 a.m. S14 RN (Registered Nurse)/Wound Care Nurse reported Resident #1 could not do anything on her own and required the Hoyer lift for transfers. S14 RN/Wound Care Nurse reported there should have been a sign over Resident #1's door indicating she required a Hoyer lift for transfers.During an interview on 09/03/2025 at 11:00 a.m. S6 agency CNA reported on 07/14/2025 she came late and was given access to the CNA charting record and her assigned residents. S6 agency CNA reported she transferred Resident #1 with a stand and pivot method and Resident #1 told her she hit her arm on the wheelchair and complained of pain. S6 agency CNA reported she notified the nurse and DON and they assessed Resident #1, an x-ray was done, and Resident #1 had a fracture. S6 agency CNA reported she did not know Resident #1 was to be transferred with a Hoyer lift until after the incident. S6 agency CNA reported she did not know how to look up a resident's transfer abilities until after the incident. When asked if she had worked at the facility before S6 agency CNA reported she had worked at the facility once before that date and had not come back until recently. S6 agency CNA reported she was in-serviced regarding obtaining information regarding proper transfer after the incident with Resident #1.During an interview on 09/03/2025 at 12:30 p.m. S2 Quality Improvement Nurse reviewed S6 agency CNA's work history in the facility and reported S6 agency CNA first worked at the facility on 04/14/2025 and did not work again at the facility until 07/01/2025. S2 Quality Improvement Nurse confirmed S6 agency CNA had worked at the facility on 07/01/2025; 07/05/2025; 07/06/2025; 07/08/2025; 07/13/2025; and 07/14/2025 and confirmed documentation of S6 agency CNA's charting record entries for the dates worked in July 2025 which indicated proficient use by the CNA of resident's care guides.