

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: 1/23 - 1/26/12</p> <p>Facility number: 000493 Provider number: 155728 AIM number: 100291300</p> <p>Survey team: Jill Ross RN-TC Diana Sidell RN Cheryl Fielden RN Janie Faulkner RN</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 3 Medicaid: 46 Other: 10 Total: 59</p> <p>Sample: 15</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/30/12 by Suzanne Williams, RN</p>	F0000		
-------	---	-------	--	--

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

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/26/2012	
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0241 SS=D	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on interview and observation, the facility failed to treat residents with dignity, in that male and female residents in adjoining rooms had to share a bathroom. This affected 2 of 4 residents reviewed for dignity in a sample of 15. (Resident # 20, Resident # 32)</p> <p>Findings include:</p> <p>During an interview with LPN #1 on 1/26/2012 at 9:45 AM, LPN#1 indicated Resident # 20 uses a bed side commode per her request and her roommate uses the bathroom shared with the men at night and uses the shower room bath toilet during the day. LPN #1 stated, "I don't know why (Resident # 20) requested to use the bedside commode instead of the bathroom.</p> <p>During an interview with Resident # 20 on 1/26/2012 at 12:20 P.M., the resident stated, "I moved here a year ago in November, and when they told me I had to share the bathroom with men, I requested a bedside commode." "It's a problem with sharing a bathroom with men for me, and the bedside commode request was the only thing my daughter</p>	F0241	Resident #20 and resident # 32 as well as their family members were offered a room change so they would not have to share the restroom with residents of the opposite sex. Both residents and families declined a room change. At the time of inquiry, before admission to the facility any prospective resident and family members will be advised that the only available bed at this time shares the restroom with the opposite sex. At that time ,they may accept admission or decline. If accepting ,and at their request ,a room change will be offered for the first room available. A new form has been put into place that informs new residents and family members of the possibility that the only available room shares the restroom with someone of the opposite sex. This form ,see attached, will be added the admission packet and explained to all new residents and or families. The Q. A. committee of this facility will monitor quarterly times four quarters that this form was used everytime a prospective resident has the possibility of being admitted to one of the affected rooms. DON and Social Service Director will monitor on an ongoing basis.	02/13/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	<p>and I could think of." "No, I didn't tell the Administrator, head nurse, or social worker." "I don't have to wait on anybody if I use the bedside commode."</p> <p>During an interview with Resident # 32's family members, they stated, "we have a concern; we feel that it is highly inappropriate for women and men to have to share a bathroom." Resident # 32 (male resident) stated, "one of the ladies always leaves the door locked and I have to go out and around through their room, so I can use the bathroom." "I have went in my pants, because I couldn't get in the bathroom quick enough." "I know we can't all have private baths, but things would be better if women shared bathroom with other women and men shared bathroom with other men." Resident # 32 's family members stated, "that is the only concern that we have, everyone here treats our Dad very good and we aren't able to provide the care he needs at home." "No we haven't talked to anyone at the facility about this."</p> <p>During an interview with the DON and Social Services on 1/26/2012 at 3:15 P.M., they both indicated they were unaware of any concerns with female residents and male residents, sharing an adjoining bathroom. " We always encourage our families and residents to</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

	share concerns." "We will discuss with the Administrator and work out an appropriate solution for all residents." 3.1-3(t)			
--	---	--	--	--