STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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 IN00430867. Complaint IN00430867 - No deficiencies related to the allegation are cited. Survey dates: March 19, 20, 21, 22 and 25, 2024 Facility number: 000217 Provider number: 155324 AIM number: 100289590 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 9 Medicaid: 39 Other: 8 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 1, 2024.	F 0000	The creation of this letter of credible allegation constitutes Mitchell Manor's written allegation of compliance. Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an allegation admission of interest against the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. This facility is respectfully requesting desk review:	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours			

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

Kathi HIgnite Owens | Executive Director | 04/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation and interview, the facility failed to ensure the staff posting information sheets were posted in a prominent place readily accessible to residents and visitors, presented in a clear and readable format, and included actual hours worked for 4 of 4 staff posting sheets reviewed. Finding include:	F 0732	It is the intent of this facility to post the following nursing staffing information on a daily basis: facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift to include	04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	On 3/25/24 at 2:50 p.m., the staff posting information sheet was located behind the nurses' station among other posted papers. The paper was not easily located nor identifiable as it was posted in among past and future staff posting sheets. The posted sheets for the dates of 3/22/24, 3/23/24, 3/24/25, and 3/25/24 did not contain the actual hours worked or the shift times. During an interview on 3/25/24 at 2:55 p.m., the Administrator indicated the staff posting sheets had always been posted behind the nurses station and the actual hours worked were updated in the computer system the next day. She indicated the posted staffing sheets did not contain the actual hours worked or the specific shift times. On 3/25/24 at 4:44 p.m., the Director of Nursing provided the policy, "Staffing," revised on 8/7/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... The facility must post the following information on a daily basis ... actual hours worked by ... staff directly responsible for resident care per shift ... 2. The facility posts daily staffing information in a clear readable format in a prominent place that is easily accessible to residents and visitors at any time ..."		registered nurse, licensed practical nurses or certified nurse aides and resident census. This will be posted by the beginning of each shift in a clear and readable format, in a prominent place readily accessible to residents and visitors. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice:** No residents were directly affected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** All residents residing in the facility have the potential to be affected by the alleged deficient practice. **What measures where put in to place and what systemic actions will be made to ensure that the deficient practice does not recur:** A new white-board which is easily identifiable as “Nursing Staff Directly Responsible for Resident Care” is now available in an easily identifiable location on the wall in direct line of sight for residents and visitors. The white board contains facility name, current date, total number and actual hours worked by the following categories of licensed and unlicensed nursing staff, certified	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
			nurse aides and resident census. The board is updated daily prior to beginning shift by the Scheduler, Manager on Duty or other designee. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** An Audit will be completed by the ED/Designee of the posted daily staffing 2 x per week x 8 weeks then monthly x 4 months to ensure compliance. Any non-compliance will be addressed immediately. Audit results will be submitted to the Quality Assurance Performance Improvement Committee for six months to ensure continuing compliance. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Health Facility Administrator is responsible for ensuring compliance with this Plan of Correction.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure accurate reconciliation and accounting for narcotic medications was implemented for 1 of 1 residents reviewed. (Resident 13) Findings include: Resident 13's clinical record was reviewed on 3/25/24 at 10:35 a.m. The diagnoses included, but	F 0755	F 755 Pharmacy Services It is the intent of this facility to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	were not limited to, depression and anxiety. Physician orders included, but was not limited to: Clonazepam (anti-anxiety medication) oral tablet 0.5 mg (milligram) give 0.25 mg by mouth two times a day for anxiety ..." The Controlled Substance Record for Resident 13's clonazepam was reviewed on 3/25/24 at 12:00 p.m. The record indicated 60 tablets were delivered on 3/13/24 at 9:26 a.m. The count indicated the following: - On 3/16/24 at 9:00 a.m., 1 tablet was given making the count 59. - On 3/16/24 at 8:00 p.m., 1 tablet was given making the count 58. - On 3/17/24 at 9:00 a.m., 1 tablet was given making the count 57. - On 3/17/24 at 8:00 p.m., 1 tablet was given making the count 56. - On 3/18/24 at 8:00 a.m., 1 tablet was given making the count 55. - On 3/18/24 at 8:00 p.m., 1 tablet was given making the count 54. - On 3/19/24 at 8:00 a.m., 1 tablet was given making the count 53. On 3/19/24 at 7:00 p.m., during the narcotic count for clonazepam for Resident 13, the count indicated 51 tablets were remaining which indicated 2 tablets were unaccounted for. During an interview on 3/20/24 at 9:51 a.m., the Administrator indicated the clonazepam count for Resident 13 was off on 3/19/24 at the 7:00 p.m. shift change. The nurse had believed she counted wrong because there were usually 6 tablets in a packet and she counted for 6 however, there were only 4 tablets in the packet after all.		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #13 was not affected and did not miss any dose of the scheduled medication. The facility replaced the two missing tablets. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** A 100% audit was completed on narcotic medications by the Director of Nursing and Assistant Director of Nursing to ensure all narcotic counts were accurate. No other discrepancies were found. **What measures were put in to place and what systemic changes will be made to ensure the deficient practice does not recur:** Under the direction of the Director of Nursing Services, nurses were re-educated on the policy on administration and documentation of controlled medications, the proper procedure for counting narcotics and the procedure for when there is a discrepancy on 4.5.2024. **How the corrective action will be monitored to ensure the deficient practice will not be recur, i.e. what quality assurance program will be put into place:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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 3/25/24 at 11:04 a.m., Registered Nurse 1 indicated she counted the missing clonazepam for Resident 13 however she believed she had counted wrong. She was not sure what happened exactly. She only gave 1 clonazepam tablet to the resident during her shift and no one else had access to her cart. 3.1-25(e)(2)		The DON/Designee will complete observation audits of the shift to shift narcotic count with various nursing staff at random times 5 x per week for one month, weekly x 4 weeks and monthly x 4 months. Audit results will be submitted to the Quality Assurance Performance Improvement Committee for six months to ensure continuing compliance. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Health Facility Administrator is responsible for ensuring compliance with this Plan of Correction.	
F 0761 SS=E 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. §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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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)(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, interview, and record review, the facility failed to label the Over the Counter (OTC) medications with resident's name for 2 of 2 medications cart observed. (B Wing Back Hall, B Wing Front Hall) Findings include: On 3/25/24 at 10:20 a.m., the back hall B wing medication cart was observed to have OTC bottles of calcium tablets, probiotic, fish oil, vitamin B 1, and sodium chloride with no resident's name. At that time, the Director of Nursing (DON) indicated the OTC medication bottles were to have resident name on them. On 3/25/24 at 11:09 a.m., the front hall B wing medication cart was observed to have an OTC bottles of acetaminophen (pain reliever), loperamide (antidiarrheal), and milk of magnesia with no resident's name. At that time, Registered Nurse (RN) 1 indicated the OTC bottles lacked residents name. On 3/25/24 at 2:34 p.m., the DON provided the facility's policy, "House Stock Items," revision date of 1/1/22 and indicated it was the policy being used by the facility. A review of the policy lacked documentation of labeling OTC medication bottles.	F 0761	It is the intent of this facility that drugs and biologicals used in the facility will be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date when applicable. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No residents were found to have been directly affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by this alleged deficient practice. **What measures were put in to place and what systemic changes will be made to ensure the deficient practice**	04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	3.1-25(l)(1)		**does not recur:** Under the direction of the Director of Nursing, all licensed nursing staff and QMAs were re-inserviced on labeling of drugs and biologicals as well as the facility policy on house stock items on April 5, 2024. **How the corrective action will be monitored to ensure the deficient practice will not be recur, i.e. what quality assurance program will be put into place:** The Director of Nursing/Designee will complete a random audit of OTC medications in the medication cart to ensure proper labeling randomly 3 days per week for one month, weekly x 2 months and biweekly x 3 months. Any area of non-compliance will be addressed immediately. Audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly x 6 months to ensure continuing compliance. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Health Facility Administrator is responsible for ensuring compliance with this Plan of Correction.	
F 0804 SS=E	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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	Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food was served in a palatable and attractive manner for 1 of 1 test tray obtained from a hall cart. (Resident 43, Resident 5, Resident 23, Resident 13, Resident 14, Resident 33, Resident 44, Resident 35, Resident 30, Resident 24, Resident 7, Resident 25) Findings include: On 3/20/24 at 9:59 a.m., Resident 43 indicated the food did not taste good and the food was often served to her room at a cold temperature. On 3/20/24 at 10:52 a.m., Resident 5 indicated the food did not taste good. On 3/21/24 at 10:49 a.m., Resident 23 indicated the food did not taste good. On 3/21/24 at 11:13 a.m., Resident 13 indicated the food was not good and was served at a cold temperature when they delivered to the room. On 3/21/24 at 11:36 a.m., Resident 14 indicated the meat was tough. On 3/21/24 at 11:41 a.m., Resident 33 indicated the	F 0804	It is the intent of this facility to provide each resident with food and drink that is palatable, attractive and at a safe and appetizing temperature. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Residents 43, 5, 23, 14, 33, 44, 35, 30, 24, 7, 14 25, 24, 13, 12 were interviewed to update food preferences. Residents are receiving palatable food according to the choices they select on the menu. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken:** All residents have the potential to be affected by the alleged issues and are receiving palatable food according to the choices they select on the menu.	04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	meat was tough. On 3/25/24 at 10:45 a.m., a resident council meeting was held. Resident 44, Resident 35, Resident 30, Resident 24, Resident 7, and Resident 25 were all in attendance. When asked about food palatability, all residents began to shake their heads "No," which indicated they did not like the taste of the food. Resident 24 indicated the food was not good and he suggested the kitchen staff needed new recipes and the menus should be changed around to offer more variety. Resident 25 indicated the facility would often serve fish multiple times a week. Resident 7 indicated the meat was very tough. On 3/25/24 at 11:23 a.m., a test tray was obtained from the B hall meal cart. The meal consisted of beef stew poured over a biscuit, cubed potatoes, a side salad, and an apple crisp dessert. The appearance of the meal tray was not immediately identifiable nor attractive to sight. The beef stew meat was gristly making it difficult to cut and chew. The potatoes were hard in texture which indicated they were undercooked. The side salad contained brown, wet, and wilted lettuce, which indicated it was not fresh. The apple crisp had very little flavor and the apples had a mushy texture which indicated they were not fresh. The following resident interviews took place after the test tray was obtained: - On 3/25/24 at 11:33 a.m., Resident 14 indicated the beef stew meat was very tough to cut up. He was able to cut it up into a bunch of pieces and was able to eat it. He further indicated the meat would be easy for someone to choke on. - On 3/25/24 at 11:34 a.m., Resident 33 indicated he		**What measures were put in to place and what systemic changes will be made to ensure the deficient practice does not recur:** All residents were interviewed to update food preferences. Under the direction of the Certified Dietary Manager, Dining Services staff were in-serviced on April 5 to include steps to ensure appropriate food temperatures throughout food service and delivery, sampling meal prior to sending out to residents as well as what to do should a meal not meet palatability standards. The resident council was convened on April 12 to discuss any ongoing issues with food. Starting in May 2024 a monthly resident food committee meeting will be held. Temperature logs will be completed at every meal and any deviation from the appropriate hot and cold holding temperature will be reported to the Dietary Manager or designee and addressed at the time. A member of the QAPI Committee will receive a test tray for two meals a day, 5 days a week x 8 weeks, then weekly for 8 weeks and then monthly for 2 months for a total of 6 months. Observations will be reported to the Dietary Manager, the QAPI Committee and discussed with residents during monthly Food Committee Meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	sent his food back because it was too tough to eat. - On 3/25/24 at 11:45 a.m., Resident 43 indicated the beef in the beef stew was tough and she could not chew it. - On 3/25/24 at 12:38 p.m., Resident 5 indicated the beef in the "beef stuff" was tough. - On 3/25/24 at 4:24 p.m., Resident 13 indicated he didn't eat any of the lunch because it looked gross and would not even try to eat it, so he sent it back. Resident 12 indicated he had never seen "meatloaf" on a biscuit before which was different. He further indicated the meat was too tough to eat, so he ate around it. During an interview on 3/25/24 at 11:35 a.m., the Administrator attempted to cut up the beef stew meet with a fork and indicated the meat on the test tray was difficult to cut and therefore chew. On 3/25/24 at 4:44 p.m., the Director of Nursing provided the facility policy, "Resident Satisfaction with Food and Dining," revised on 4/25/23, and indicated it was the current policy being used. A review of the policy indicated, " ... Each resident receives and the facility provides - Food prepared by methods that conserve ... flavor, and appearance ... Food and drink that is palatable, attractive ..." 3.1-21(a)(1) 3.1-21(a)(2)		**How the corrective action will be monitored to ensure the deficient practice will not be recur, i.e. what quality assurance program will be put into place:** Dining Service Manager will conduct audit 5 x week at various meal service times to ensure palatability, temperature and appearance are maintained to the point that the resident receives the meal for one month, weekly x 4 weeks and monthly x 4 months. . Audit tools will include temperature logs and meal evaluation form. A member of the QAPI Committee will receive a test tray for two meals a day, 5 days a week x 8 weeks, then weekly for 8 weeks and then monthly for 2 months for a total of 6 months. Observations will be reported to the Dietary Manager, the QAPI Committee and discussed with residents during monthly Food Committee Meeting. Audits will be reported to the Quality Assurance Performance Improvement Committee ongoing. This plan of correction will be monitored until such time consistent substantial compliance has been met. The QAPI committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated The Health Facility Administrator	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
			is responsible for ensuring compliance with this Plan of Correction.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure a urinary drainage bag and tubing was positioned off the	F 0880	It is the intent of this facility to establish and maintain an infection prevention and control program	04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	floor for 1 of 1 residents reviewed for urinary catheter. (Resident 52) Findings include: On 3/19/24 at 12:39 p.m., Resident 52 was observed to be sitting in his wheelchair in the dining room. The urinary drainage tubing was observed to be touching the floor. On 3/21/24 at 1:17 p.m., Resident 52 was observed to be rolling around the hallway in his wheelchair. The urinary drainage tubing was observed to be dragging on the floor. On 3/21/24 at 3:06 p.m., Resident 52 was observed to be sitting in his wheelchair in his room. The urinary drainage tubing was observed to be touching the floor. On 3/22/24 at 12:41 p.m., Resident 52 was observed to be sitting in his wheelchair in his room. The urinary drainage bag and tubing were observed to be touching the floor. On 3/25/24 at 10:26 a.m., Resident 52 was observed to be rolling around the hallway in his wheelchair. The urinary drainage tubing was observed to be dragging on the floor. On 3/25/24 at 1:32 p.m., Resident 52 was observed to be rolling around the hallway in his wheelchair. The urinary drainage tubing was observed to be dragging on the floor. On 3/25/24 at 4:34 p.m., Resident 52 was observed to be sitting in his wheelchair at the end of the hall. The urinary drainage tubing was observed to be touching the floor.		designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. **Immediate action taken for those residents identified**: Resident 52 no longer has a catheter **How the facility identified other residents**: No residents in the facility have a catheter. **Measures put into place/systemic changes:** The Director of Nursing Prepared initiated an inservice on April 5, 2024 for all Licensed Nurses and Certified Nursing Assistants on the facility policy for catheters including maintaining the urinary drainage bag tubing off the floor. The DON/Designee will conduct audits 5 x week on all residents with urinary catheters over the next six months to ensure sustained compliance with maintaining the urinary drainage bag tubing off the floor. Any instances of non-compliance will be addressed immediately. Audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly x 6 months to ensure continuing compliance. The committee will review and monitor the results of the performance improvement action plan and will extend or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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 52's clinical record was reviewed on 3/22/24 at 10:20 a.m. The diagnosis included, but was not limited to, benign prostatic hyperpiesia with lower urinary tract symptoms. During an interview on 3/25/24 at 1:19 p.m., Certified Nursing Assistant (CNA) 1 indicated the urinary drainage bag and tubing should be positioned off the floor. During an interview on 3/25/24 at 4:35 p.m., CNA 2 indicated the urinary drainage bag tubing for Resident 52 was currently touching the floor. On 3/25/24 at 2:34 p.m., the Director of Nursing provided the facility's policy,"Indwelling Urinary Catheter [Foley] Management" with a reviewed date of 8/24/23, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... General Urinary Catheter Maintenance Guidelines ... 2. Maintain unobstructed urine flow ... b. keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor ..." The policy did not mention the urinary drainage bag tubing. 3.1-18(b)(1)		modify if necessary in order to sustained compliance.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a homelike environment free of damage and disrepair for of 7 of 9 residents reviewed for environmental concerns (Resident 19, Resident 23, Resident 14, Resident 33, Resident 28, Resident 36, and	F 0921	It is the intent of this facility to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. **Immediate actions taken for those residents identified**:	04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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 43). Findings include: 1. On 3/20/24 at 10:00 a.m., the light in Resident 43's shower was observed to not function. During an interview on 3/20/24 at 10:01 a.m., Resident 43 indicated the shower was dark and would like to have a light in the shower that worked. 2. On 3/20/24 at 10:05 a.m., an electrical outlet sized hole was observed in the wall behind Resident 36's bed. 3. On 3/20/24 at 11:33 a.m., Resident 19's call light pull was observed to be approximately 1 inch long and difficult to grasp. There were holes in the netting of the privacy curtains observed in the room. 4. On 3/21/24 at 10:48 a.m., the paint on the wall at the head of Resident 23's bed was observed to be scraped, revealing the bare drywall. 5. On 3/21/24 at 11:04 a.m., the door of Resident 28's closet was observed to be off the guide rails. The wall behind the bed was observed to be dirty and scuffed. 6. On 3/21/24 at 11:38 a.m., Resident 14 and Resident 33's room was observed to be missing baseboards, revealing scraped and scuffed drywall. During an interview on 3/25/24 at 12:58 p.m., the Physical Plant Director indicated the aforementioned environmental concerns existed and required repair.		Resident 19 had call pull cord replaced, resident 23 had paint touched up at head of bed, cove base replaced for residents 14 & 33, closet door placed back on track for resident 28, electrical plate cover replaced for resident 36, light in shower replaced for resident 43. **How the facility identified other residents**: An environmental audit was conducted of all resident rooms to identify any similar issues. Repairs will be done to areas that are identified from this audit. **Systemic Changes:** Under the direction of the Executive Director staff were educated on the use of the Maintenance Request on 4. 5.24. Angel rounds as assigned will be completed by managers at least 5 days a week and they will document on their rounds checklist areas needing repair. The sheets will be reviewed in the morning stand up meeting. **How the corrective action will be monitored**: Administrator/Designee will complete Environment Quality Assurance Worksheet on 5 rooms weekly x 8 weeks and monthly ongoing for a total of six months. The maintenance director will be responsible for compliance. Audits will be forwarded to the Quality Assurance Performance Improvement Committee monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	03/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(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
	On 3/25/24 at 2:55 p.m., the facility Administrator provided the Resident Rights, undated, and indicated these were the Resident Rights currently utilized by the facility. A review of the Resident Rights indicated, "...the resident has the right to a safe, clean, comfortable, and homelike environment..." 3.1-19(f)		for six months or until substantial compliance is achieved. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. The Health Facility Administrator is responsible for ensuring compliance with this Plan of Correction.	