CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED		
155324		B. WING		07/26/2023			
		1			****		
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD			
TWINE OF I	I RO VIDER OR SETTEE		24 TEI	KE BURTON DR			
MITCHE	LL MANOR		MITCH	HELL, IN 47446			
(V4) ID	CIDAMADY	CTATEMENT OF DESIGNATE	ID.	1	(7/5)		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
F 0000							
Bldg. 00							
	This visit was for the	ne Investigation of Complaints	F 0000	The creation of this letter of			
	IN00411093, IN00412357, and IN00413267.			credible allegation constitutes	6		
				Mitchell Manor's written alleg			
	Complaint IN00411	1093 - No deficiencies related to		of compliance. Submission o	l l		
	allegations are cited			plan of correction is not a legal			
	anegations are enec			1 .			
	C1-:4 IN100412	2257 N. 4-6-11-4-44-		admission that a deficiency e	l l		
	_	2357 - No deficiencies related to		or that this statement of defic	•		
	allegations are cited	1.		was correctly cited, and is als	60		
				not to be construed as an			
		3267 - Federal/State deficiencies		admission of interest against	the		
	related to the allega	ations are cited at F760 and		facility, the Administrator or a	ny		
	F880			employees, agents, or other			
				individuals who draft or may	be		
	Survey dates: July 2	20, 21, and 26, 2023		discussed in this response ar			
		,,,		plan of correction. In addition			
	Facility number: 00	00217		preparation of this plan of	'		
	Provider number: 1						
				correction does not constitute			
	AIM number: 1002	.89390		admission or agreement of a	-		
				kind by the facility of the truth	of		
	Census Bed Type:			any facts alleged or see the			
	SNF/NF: 45			correctness of any allegation	- I		
	Total: 45			the survey agency. The facili	ty is		
				respectfully requesting a des	k		
	Census Payor Type	::		review.			
	Medicare: 5						
	Medicaid: 37						
	Other: 3						
	Total: 45						
	These deficiencies	reflect State Findings cited in					
	accordance with 41	9					
	accordance with 41	V IAC 10.2-3.1.					
	01	1-4-4 I121 2022					
	Quality review com	npleted July 31, 2023.					
E 0700	400 45(5)(6)						
F 0760	483.45(f)(2)						
SS=D		ee of Significant Med Errors					
Bldg. 00	The facility must e	ensure that its-					

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

TITLE (X6) DATE

Katherine A Hignite Owens Executive Director 08/04/2023

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: BW5Y11 Facility ID: 000217 If continuation sheet Page 1 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING <u>00</u>		COMPLETED		
155324			B. WING 07/26/2023				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					E BURTON DR		
MITCHELL MANOR				MITCH	ELL, IN 47446		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG			+	TAG DEFICIENCY)			DATE
	significant medica	idents are free of any tion errors					
	Based on interview and record review, the facility failed to ensure a resident was free from a		F 07	760	F 760 It is the intent of this facility		08/03/2023
			1 0	. 00	to ensure residents are free of		
	significant medication error for 1 of 3 residents				significant medication errors.		
	reviewed. A resident received the wrong dose of				What Corrective Action will b	е	
	fast acting insulin. (Resident B, Resident C)				accomplished for those		
					residents found to have beer	า	
	Finding includes: During an interview on 7/21/23 at 11:03 a.m.,				affected by the alleged		
					deficient practice:		
					LPN #1 was educated/counse		
	Resident B indicated he received too much insulin				by the Director of Nursing as a		
	from LPN 1 (Licensed Practical Nurse) a few weeks				result of the insulin error. Resi		
	ago. LPN 1 informed Resident B he had			vital signs were monitored and			
	administered 30 units of insulin. LPN 1 also told			facility protocol was followed per		er	
	Resident B he admi	nistered the wrong insulin.		medication error policy and			
	D	7/21 22 4 1 10 1 1 1 1 1			procedure. The resident did no	ot	
	_	on 7/21 23 at 1:18 p.m., LPN 1			have a negative outcome.		
		3 he administered Resident C's			Resident B and C physician at		
	_	ose to Resident B by mistake. Resident C's room and into		RP was notified of the medication		uon	
	_	by mistake because the power			error.		
		form. LPN 1 administered			How other residents having t	the	
	_	nacks to help keep Resident			potential to be affected by th		
		n dropping. The insulin LPN 1			same alleged deficient practi		
		sident B was from Resident C's			will be identified and what		
	insulin pen that was already opened and used for				corrective actions will be		
		took the insulin pen back to the			taken:		
		noved the needle, replaced the			Residents who receive insulin	have	
	cap, and placed the	pen back in the medication			the potential to be affected.		
	cart.				The DON/designee has comp	leted	
					an audit of med carts and med	ł	
		for Resident B was reviewed			rooms to ensure residents		
		a.m. The diagnoses included,			receiving insulin have the		
		l to, diabetes and long term use			appropriate insulin per their		
	of insulin.				physician orders available for		
					The DON/designee will provid		
	A quarterly MDS (N				education to licensed nurses of	on	
		/26/23, indicated Resident B			insulin administration		
was cognitively intact.			1		What measures will be put in	ito	l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING 00 CC		COMPL	COMPLETED	
155324			B. WING 07/26/2023			2023	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					E BURTON DR		
MITCHELL MANOR					ELL, IN 47446		
INTO THE LIVER WOOL				IVII I OI II	, //		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The Physician's orders included, but were not limited to: - Insulin lispro solution (fast acting insulin that				place and what systemic		
					changes will be made to		
					ensure the alleged deficient		
					practice does not recur:		
					Licensed nurses provided with		
	should be administered by injection within 15				Medication Administration Tra	_	
	minutes before meals or right after eating a meal)				including insulin administration		
	,	iters). Inject as per sliding scale:			Training included identification		
	if blood sugar is 141-180 give 2 units; 181-220 give				medication order, guidelines for	or	
	_	ve 6 units; 261-300 give 8 units;			medication administration,		
	301-340 give 10 units; 341-380 12 units; 381-420 give 14 units; 421-460 give 16 units; 461-482 give				avoiding medication errors, six	X	
					rights of medication	oro	
	18 units. Administer insulin subcutaneously, before meals, and call the physician if blood sugar				administration, medication err		
	is 482 or greater, in		and infection control concepts				
	15 402 of greater, in	mateu 3/23/23.			during administration of		
	The June 2022 Mad	lication Administration Record			medications. The six rights	nt	
	indicated:	neation Administration Record	included right drug, right patient,				
	muicateu.				right dose, right time, right rou and right documentation.	il C	
	On 6/29/23 at 4·30	p.m., Resident B's blood sugar			and right documentation.		
	l '	B should have received 6 units					
	of insulin lispro.				How the corrective action wi	II	
					be monitored to ensure the		
	A progress note. da	ted 6/29/23 at 9:12 p.m.,			deficient practice will not		
		B's blood sugar results were			recur, i.e. what quality		
		se Practitioner for the evening			assurance program will be p	ut	
	of 6/29/23. The blood sugar results at 7:00 p.m.,				into place:	- =	
		6, at 9:00 p.m., 62, and at 9:30			DON or designee will perform		
	p.m., 116.	• •		observations of insulin			
	_				administration at the following		
	The clinical record	for Resident C was reviewed			frequency – 5 observations pe		
	on 7/21/23 at 10:19	a.m. The diagnoses included,			week x 30 days, then 3		
	but were not limited	d to, diabetes and cancer.			observations per week x 30 da	ays,	
					then weekly x 4 months.	-	
	A quarterly MDS as	ssessment, dated 4/21/23,			Insulin errors will be followed	up	
	indicated Resident	C was cognitively intact.			by the DON/designee and bro	•	
					to daily clinical review 5	=	
	The Physician's ord	lers included, but were not			days/week (except for holiday	S	
	limited to:				and weekends) for IDT review		
					each occurrence on an ongoir	-	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155324	B. WING 07/26/2023				2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER				E BURTON DR			
MITCHFI	L MANOR				ELL, IN 47446			
					, .			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
		tion (fast acting insulin that			basis. All licensed nurses were	е		
		ered by injection within 10			educated on "Medication			
		ng a meal) pen-injector 100			Administration".			
		nits subcutaneously before			The DON/Designee will bring			
	meals, initiated 10/27/22.				results of the audits to the Qua	ality		
					Assurance Performance			
	_	dated 6/29/23 at 5:02 p.m.,			Improvement Committee mon	•		
		B was given insulin dose in			for six months until full complia			
		as given sugary snacks to			has been achieved for a total			
		The Director of Nursing			months of monitoring. Frequer	-		
	educated LPN 1 on	6 rights.			and duration of reviews will be			
					increased as needed, if areas			
		p.m., the Director of Nursing			noncompliance exist. Plan to b			
		a facility document, titled			updated by QAPI committee a	S		
		ion Competency Checklist,			indicated.			
		ndicated this was the			The Health Facility Administra			
		s reviewed with LPN 1. A			at Mitchell Manor is responsib			
	-	etency indicated ask			for ensuring compliance with t	his		
	-	the resident's room and			plan of correction.			
	identify the resident							
	This Federal Tag re	lates to Complaint IN00413267.						
	3.1-48(c)(2)							
F 0880	402.00(6)(4)(0)(4)	(a)(f)						
SS=D	483.80(a)(1)(2)(4)							
	Infection Prevention							
Bldg. 00	§483.80 Infection							
	•	stablish and maintain an						
	•	on and control program						
		le a safe, sanitary and						
		onment and to help prevent						
	•	and transmission of						
	communicable dis	eases and infections.						
	8/83 80(a) Infaction	on prevention and control						
	program.	on prevention and control						
	. •	stablish an infection						
		ntrol program (IPCP) that						
		minimum, the following						
	actoiaac, at a		1				l	

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

Event ID:

BW5Y11 Facility ID: 000217

If continuation sheet Page 4 of 9

A BUILDING 00 COMPLETED 07/26/2023 NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR IDENTIFICATION NUMBER 155324 NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR IDENTIFICATION NUMBER 24 TEKE BURTON DR MITCHELL, IN 47446 IDENTIFIED OR PROVIDER APPROPRIATE CROSS REFERENCION DR MITCHELL, IN 47446 IDENTIFIED OR PROVIDER APPROPRIATE CROSS REFERENCION DATE REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION DATE REGULATORY OR LSC IDENTIFY INFORMATION DATE R	STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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			A. BU						
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR 24 TEKE BURTON DR MITCHELL, IN 47446 (X4) ID PREFIX CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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	155324			B. W.	ING		07/26/	/2023	
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CX4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG	NAME OF P	NOVIDER OR SUPPLIER	\						
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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									
include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or		= ', ', '							
(i) A system of surveillance designed to identify possible communicable diseases or									
identify possible communicable diseases or		include, but are not limited to:							
		(i) A system of surveillance designed to							
infections before they can spread to other			· · ·						
persons in the facility;		_ ·	-						
(ii) When and to whom possible incidents of		1 ' '	-						
communicable disease or infections should			sease or infections should						
be reported;		1							
(iii) Standard and transmission-based		1 ' '							
precautions to be followed to prevent spread		l •	followed to prevent spread						
of infections;		· ·	ricolation should be used						
(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		1	_						
(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			22.mast viii danomit dio						
(vi)The hand hygiene procedures to be		i i	ene procedures to be						

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

Event ID:

BW5Y11 Facility ID: 000217

If continuation sheet

Page 5 of 9

PRINTED: 08/09/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED		
		155324	B. WING		07/26/2023	
	PROVIDER OR SUPPLIEI	2	24 TE	ADDRESS, CITY, STATE, ZIP COD KE BURTON DR IELL, IN 47446		
(X4) ID	SUMMADV	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		
TAG	`	R LSC IDENTIFYING INFORMATION		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAU	+		TAG		DATE	
	contact.	nvolved in direct resident				
	8483 80(a)(4) A s	ystem for recording				
		d under the facility's IPCP				
		actions taken by the				
	facility.	actions taken by the				
	lacility.					
	§483.80(e) Linens					
	- ' '					
	Personnel must handle, store, process, and transport linens so as to prevent the spread					
	of infection.	o as to prevent the spread				
	or infection.					
	8/83 80(f) Appus	Lreview				
	§483.80(f) Annual review. The facility will conduct an annual review of					
	1					
	•	ate their program, as				
	necessary.	and record review, the facility	E 0000	FOOD It is the intent of this fooi	00/02/2022	
		-	F 0880	F880 It is the intent of this faci	08/03/2023	
		ection control practices were		to establish and maintain an		
		residents reviewed. A resident		infection prevention and control	•	
		nother resident's used insulin		program designed to provide a	•	
	pen. (Resident B, R	Lesident C)		safe, sanitary and comfortable	•	
				environment and to help preven	•	
	Finding includes:			the development and transmis	•	
	D	7/01/02 + 11 02		of communicable diseases an	a	
		v on 7/21/23 at 11:03 a.m.,		infections.		
		ed LPN 1 told Resident B he		What Corrective Action will be	pe	
	had administered th	e wrong insulin.		accomplished for those		
		5 /01/02 + 1/10 5 5 5 5		residents found to have been	۱	
	_	v on 7/21 23 at 1:18 p.m., LPN 1		affected by the alleged		
		3, he administered Resident C's		deficient practice:		
	_	lose pen to Resident B by		LPN 1 was educated/counsel		
		n pen LPN 1 administered to		by the Director of Nursing as a	a	
		m Resident C's insulin pen that		result of the medication error.		
	was already opened	l and used for Resident C.		Resident vital signs were		
				monitored and facility protocol	was	
		dated 6/29/23 at 5:02 p.m.,		followed per medication error		
		B was given insulin dose in		policy and procedure. The res	ident	
	error. Resident B w	as given sugary snacks to		did not have a negative outcome	me.	

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counteract effects. The Director of Nursing

Event ID:

BW5Y11

Facility ID: 000217

If continuation sheet

Resident B and Resident C have

Page 6 of 9

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

PRINTED: 08/09/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155324		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/26/2023				
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5) JLD BE PROPRIATE COMPLETION DATE			
	educated LPN 1 on	-		been provided with new pens from the pharmacy				
	Nursing provided a Guidance for Using and indicated this was the facility. A revidend needles should residents.	p.m., the Regional Director of copy of a facility policy, titled Insulin Products, dated 2021, was the current policy used by the policy indicated pensinever be used between elates to Complaint IN00413267.		How other residents ha potential to be affected same alleged deficient will be identified and will taken: No other residents were by the deficient practice. event a medication error identified facility policy as procedure will be followed Other residents who receinsulin have the potential affected. The DON/design provided licensed nursing insulin administration. What measures will be place and what systemichanges will be made to ensure the alleged deficing provided licensed nursing including insulin administration. Training included identification Administration including insulin administration including medication administration avoiding medication error rights of medication administration administration, medication administration, medication and infection control conduring administration of medications. The six right dose, right time, right right dose, right time, right	ving the by the practice hat be affected In the is nd ad. eive I to be gnee has g staff put into ic o cient : d with on Training tration. cation of a ines for n, ors, six on errors cepts hts patient,			
				and right documentation.				

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

Event ID:

BW5Y11 Facility ID: 000217

If continuation sheet Page 7 of 9

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

PRINTED: 08/09/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155324		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/26/2023				
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR					
MITCHELL MANOR				HELL, IN 47446				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				How the corrective action we be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be pinto place: DON or designee will performinsulin administration observations per week x 30 of then 3 observations per week days, then weekly x 4 months Insulin errors will be followed by the DON and brought to declinical review 5 days/week (except for holidays and weekends) for IDT review uper each occurrence on an ongoin basis. All licensed nurses were ducated on "Medication Administration". The DON/Designee will bring results of the audits to the Quant Assurance Performance Improvement Committee more for six months until full complete has been achieved for a total months of monitoring. Frequent and duration of reviews will be increased as needed, if areas noncompliance exist. Plan to updated by QAPI committee indicated. The Health Facility Administration of correction.	n ations alays, a x 30 s. I up ailly on ang re the ality athly iance of six ency ee s of be as ator ole			

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

Event ID:

BW5Y11 Facility ID: 000217

If continuation sheet

Page 8 of 9

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/09/2023 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155324	B. WING			07/26/2023	
NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
							1

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: $BW5Y11 \quad \ \ {\rm Facility\ ID:} \quad \ 000217$ If continuation sheet Page 9 of 9