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	07/26/2023

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 the Investigation of Complaints IN00411093, IN00412357, and IN00413267. Complaint IN00411093 - No deficiencies related to allegations are cited. Complaint IN00412357 - No deficiencies related to allegations are cited. Complaint IN00413267 - Federal/State deficiencies related to the allegations are cited at F760 and F880 Survey dates: July 20, 21, and 26, 2023 Facility number: 000217 Provider number: 155324 AIM number: 100289590 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 5 Medicaid: 37 Other: 3 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 31, 2023.	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 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. The facility is respectfully requesting a desk review.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must 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 defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	07/26/2023

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(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free from a significant medication error for 1 of 3 residents reviewed. A resident received the wrong dose of fast acting insulin. (Resident B, Resident C) Finding includes: During an interview on 7/21/23 at 11:03 a.m., Resident B indicated he received too much insulin from LPN 1 (Licensed Practical Nurse) a few weeks ago. LPN 1 informed Resident B he had administered 30 units of insulin. LPN 1 also told Resident B he administered the wrong insulin. During an interview on 7/21 23 at 1:18 p.m., LPN 1 indicated on 6/29/23 he administered Resident C's fast acting insulin dose to Resident B by mistake. LPN 1 walked past Resident C's room and into Resident B's room by mistake because the power went out during a storm. LPN 1 administered sugary drinks and snacks to help keep Resident B's blood sugar from dropping. The insulin LPN 1 administered to Resident B was from Resident C's insulin pen that was already opened and used for Resident C. LPN 1 took the insulin pen back to the medication cart, removed the needle, replaced the cap, and placed the pen back in the medication cart. The clinical record for Resident B was reviewed on 7/21/23 at 10:31 a.m. The diagnoses included, but were not limited to, diabetes and long term use of insulin. A quarterly MDS (Minimum Data Set) assessment, dated 6/26/23, indicated Resident B was cognitively intact.	F 0760	F 760 It is the intent of this facility to ensure residents are free of any significant medication errors. **What Corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice:** LPN #1 was educated/counseled by the Director of Nursing as a result of the insulin error. Resident vital signs were monitored and facility protocol was followed per medication error policy and procedure. The resident did not have a negative outcome. Resident B and C physician and RP was notified of the medication error. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken:** Residents who receive insulin have the potential to be affected. The DON/designee has completed an audit of med carts and med rooms to ensure residents receiving insulin have the appropriate insulin per their physician orders available for use. The DON/designee will provide education to licensed nurses on insulin administration **What measures will be put into**	08/03/2023

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	07/26/2023

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
	The Physician's orders included, but were not limited to: - Insulin lispro solution (fast acting insulin that should be administered by injection within 15 minutes before meals or right after eating a meal) 100 units/ml (milliliters). Inject as per sliding scale: if blood sugar is 141-180 give 2 units; 181-220 give 4 units; 221-260 give 6 units; 261-300 give 8 units; 301-340 give 10 units; 341-380 12 units; 381-420 give 14 units; 421-460 give 16 units; 461-482 give 18 units. Administer insulin subcutaneously, before meals, and call the physician if blood sugar is 482 or greater, initiated 3/23/23. The June 2023 Medication Administration Record indicated: On 6/29/23 at 4:30 p.m., Resident B's blood sugar was 234. Resident B should have received 6 units of insulin lispro. A progress note, dated 6/29/23 at 9:12 p.m., indicated Resident B's blood sugar results were reported to the Nurse Practitioner for the evening of 6/29/23. The blood sugar results at 7:00 p.m., 101, at 8:00 p.m., 96, at 9:00 p.m., 62, and at 9:30 p.m., 116. The clinical record for Resident C was reviewed on 7/21/23 at 10:19 a.m. The diagnoses included, but were not limited to, diabetes and cancer. A quarterly MDS assessment, dated 4/21/23, indicated Resident C was cognitively intact. The Physician's orders included, but were not limited to:		**place and what systemic changes will be made to ensure the alleged deficient practice does not recur:** Licensed nurses provided with Medication Administration Training including insulin administration. Training included identification of a medication order, guidelines for medication administration, avoiding medication errors, six rights of medication administration, medication errors and infection control concepts during administration of medications. The six rights included right drug, right patient, right dose, right time, right route and right documentation. **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:** DON or designee will perform observations of insulin administration at the following frequency – 5 observations per week x 30 days, then 3 observations per week x 30 days, then weekly x 4 months. Insulin errors will be followed up by the DON/designee and brought to daily clinical review 5 days/week (except for holidays and weekends) for IDT review upon each occurrence on an ongoing	

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	07/26/2023

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
	- Insulin aspart solution (fast acting insulin that should be administered by injection within 10 minutes before eating a meal) pen-injector 100 units/ml. Inject 30 units subcutaneously before meals, initiated 10/27/22. An incident report, dated 6/29/23 at 5:02 p.m., indicated Resident B was given insulin dose in error. Resident B was given sugary snacks to counteract effects. The Director of Nursing educated LPN 1 on 6 rights. On 7/20/23 at 2:30 p.m., the Director of Nursing provided a copy of a facility document, titled Insulin Administration Competency Checklist, dated 6/29/23, and indicated this was the competency that was reviewed with LPN 1. A review of the competency indicated ask permission to enter the resident's room and identify the resident. This Federal Tag relates to Complaint IN00413267. 3.1-48(c)(2)		basis. All licensed nurses were educated on “Medication Administration”. The DON/Designee will bring the results of the audits to the Quality Assurance Performance Improvement Committee monthly for six months until full compliance has been achieved for a total of six months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. Plan to be updated by QAPI committee as indicated. The Health Facility Administrator at Mitchell Manor 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			

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	07/26/2023

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
	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 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			

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	07/26/2023

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
	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 interview and record review, the facility failed to ensure infection control practices were followed for 1 of 3 residents reviewed. A resident was administered another resident's used insulin pen. (Resident B, Resident C) Finding includes: During an interview on 7/21/23 at 11:03 a.m., Resident B indicated LPN 1 told Resident B he had administered the wrong insulin. During an interview on 7/21 23 at 1:18 p.m., LPN 1 indicated on 6/29/23, he administered Resident C's fast acting insulin dose pen to Resident B by mistake. The insulin pen LPN 1 administered to Resident B was from Resident C's insulin pen that was already opened and used for Resident C. An incident report, dated 6/29/23 at 5:02 p.m., indicated Resident B was given insulin dose in error. Resident B was given sugary snacks to counteract effects. The Director of Nursing	F 0880	F880 It is the intent of this facility to 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. **What Corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice:** LPN 1 was educated/counseled by the Director of Nursing as a result of the medication error. Resident vital signs were monitored and facility protocol was followed per medication error policy and procedure. The resident did not have a negative outcome. Resident B and Resident C have	08/03/2023

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	07/26/2023

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
	educated LPN 1 on 6 rights. On 7/26/23 at 9:30 p.m., the Regional Director of Nursing provided a copy of a facility policy, titled Guidance for Using Insulin Products, dated 2021, and indicated this was the current policy used by the facility. A review of the policy indicated pens and needles should never be used between residents. This Federal Tag relates to Complaint IN00413267. 3.1-18(b)(1)		been provided with new insulin pens from the pharmacy **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective actions will be taken:** No other residents were affected by the deficient practice. In the event a medication error is identified facility policy and procedure will be followed. Other residents who receive insulin have the potential to be affected. The DON/designee has provided licensed nursing staff insulin administration. **What measures will be put into place and what systemic changes will be made to ensure the alleged deficient practice does not recur:** Licensed nurses provided with Medication Administration Training including insulin administration. Training included identification of a medication order, guidelines for medication administration, avoiding medication errors, six rights of medication administration, medication errors and infection control concepts during administration of medications. The six rights included right drug, right patient, right dose, right time, right route and right documentation.	

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	07/26/2023

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
			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: DON or designee will perform insulin administration observations at the following frequency – 5 observations per week x 30 days, then 3 observations per week x 30 days, then weekly x 4 months. Insulin errors will be followed up by the DON and brought to daily clinical review 5 days/week (except for holidays and weekends) for IDT review upon each occurrence on an ongoing basis. All licensed nurses were educated on “Medication Administration”. The DON/Designee will bring the results of the audits to the Quality Assurance Performance Improvement Committee monthly for six months until full compliance has been achieved for a total of six months of monitoring. Frequency and duration of reviews will be increased as needed, if areas of noncompliance exist. Plan to be updated by QAPI committee as indicated. The Health Facility Administrator at Mitchell Manor is responsible for ensuring compliance with this plan of correction.	

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	07/26/2023

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