STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING 00 B. WING	01/27/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00398708. Complaint IN00398708 - Unsubstantiated due to lack of evidence. Survey dates: January 23, 24, 25, 26, and 27, 2023. Facility number: 000493 Provider number: 155728 AIM number: 100291300 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicare: 7 Medicaid: 26 Other: 8 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 31, 2023.	F 0000	We respectfully request a desk review of the following plan of correction to our annual survey event ID: QB6Z11 conducted at Manderley Health Care Center survey dates January 23, 24, 25, 26, and 27, 2023. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited, however, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal Law. Manderley Health Care Center desires this Plan of Correction to be considered the facility's Allegation of Compliance effective date: February 24, 2023.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Molly Negangard	Health Facility Administrator	02/15/2023

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.

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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician of a resident's refusal of medications for 1 of 14 residents reviewed. (Resident 4) Findings include: The clinical record for Resident 4 was reviewed on 01/25/23 at 11:32 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/03/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, end stage renal disease, anemia, hypertension, diabetes, seizure disorder, anxiety, depression, and bipolar. A physician's orders, dated 12/28/22 through 12/30/22 and 12/31/22 through 01/19/23, indicated the resident was to take Patiromer Sorbitex Calcium (a medication for hyperkalemia), take 16.8 grams, once a day. A physician's order, dated 12/27/22 through 01/18/23, indicated the resident was to take Miralax (a bowel medication), 17 grams, twice a day. The December 2022 and January 2023 EMAR/ETAR (Electronic Medication Administration/Electronic Treatment Administration Record) indicated the resident had refused the medications the following dates and times: -12/27/22, Miralax at 8:00 P.M., - 12/28/22, Patiromer at 6:00 A.M., Miralax at 8:00 P.M.,	F 0580	**It is the practice of this facility to assure that residents' physician/resident representative are notified when changes occur.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #4's physician was notified of refusal to take medication. The medications listed in the 2567 were discontinued per MD order on 1/18/23 & 1/19/2023. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that the residents' physician is aware if the resident refuses medication. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses and QMA's have been in-serviced related to notifying a resident's physician of medication refusals. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly	02/24/2023

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	- 12/29/22, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 12/30/22, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 12/31/22, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., and 8:00 P.M., - 01/01/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/02/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/03/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/04/23, Miralax at 8:00 A.M., and 8:00 P.M., - 01/05/23, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., and 8:00 P.M., - 01/06/23, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., and 8:00 P.M., - 01/07/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/08/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/09/23, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., and 8:00 P.M., - 01/10/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/11/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/12/23, Patiromer at 6:00 A.M., - 01/13/23, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., and 8:00 P.M., - 01/14/23, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., - 01/15/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/16/23, Patiromer at 6:00 A.M., Miralax at 8:00 P.M., - 01/17/23, Patiromer at 6:00 A.M., Miralax at 8:00 A.M., and 8:00 P.M., - 01/18/23, Patiromer at 6:00 A.M., and - 01/19/23, Patiromer at 6:00 A.M.		reviews 5 residents to assure that if a resident has refused medications that the physician has been notified. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** 2-24-23	

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	The clinical record lacked documentation the physician had been notified of the resident's refusal of the medications until 01/19/23. During an interview on 01/26/23 at 10:57 A.M., RN 2 indicated if a resident refused their medications the nurse would document the refusal in the EMAR, input a progress note, and notify the physician. The current facility policy, titled "Medication Administration General Guidelines", with a review date of 05/20/20, was provided by the DON on 01/26/23 at 1:12 P.M. The policy indicated, "...Document any scheduled medication(s) that is withheld, refused, or given at a different time than scheduled. MAR/eMAR should have the licensed personnel initials circled for the medication(s) with an explanation written in the proper area on the backside of MAR/eMAR page designated. Any vital medication(s) refused, or more than one dose of a medication refused should be reported to the DON/designee and/or physician according to facility policy..." The current facility policy titled "Change in Resident's Condition or Status", with a revised date of 12/16/21, was provided by the DON (Director of Nursing) on 01/26/23 at 1:12 P.M. The policy indicated, "...The nurse will notify the resident's Attending Physician of physician on call when there has been a(an)...f. refusal of treatment or medication two (2) or more consecutive times..." 3.1-5(a)(2)			
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage for 1 of 14 residents reviewed for quality of care. (Resident 47) Findings include: During a medication administration observation on 01/24/23 at 11:11 A.M., RN 2 removed the cap of the Aspart insulin pen, applied the needle, held the pen sideways, and turned the knob on the end of the pen to the dose of 23 units. She went into Resident 47's room and administered the insulin in the resident's left upper arm. During an interview on 01/24/23 at 11:33 A.M., RN 2 indicated she should have cleaned the end of the insulin pen before applying the needle. She only primed the insulin pen when the pen was new and being used for the first time. The package insert for Aspart Flex Pen Insulin was provided by the DON (Director of Nursing) on 01/26/23 at 1:12 PM. The Instructions For Use indicated, "...Preparing your insulin...Pen...Pull off the pen cap...Wipe the rubber stopper with an alcohol swab...Before each injection...Turn the dose selector to select 2 units...Hold...Pen with the needle pointing up. Tap the cartridge gently with	F 0684	**It is the practice of this facility to assure that insulin pens are cleaned and primed per manufacturer's guidelines.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #47 is having insulin pen cleaned/primed prior to administration in accordance with the manufacturer's guidelines. ***Other residents that have the potential to be affected have been identified by:*** All diabetic residents that are using insulin pens have been reviewed to assure insulin pens are cleaned/primed prior to administration in accordance with manufacturer's guidelines. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses have been in-serviced on cleaning and priming insulin pens prior to administration in accordance with the	02/24/2023

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	your finger a few times to make any air bubbles collect at the top of the cartridge...Keep the needle pointing upwards, press the push-button all the way in...A drop of insulin should appear at the needle tip..." The current Insulin Preparation and Administration policy, with a reviewed date of 05/20/20, was provided by the DON on 01/26/23 at 2:30 P.M. The policy indicated, "...Remove cap from the pen and wipe needle attachment area with alcohol swab...attach needle to the pen...Remove the outer needle cap and save; remove inner needle cap and discard...Remove air from the insulin pen...Turn the dial to 2 units...Hold pen and point needle up...Gently tap pen to move air bubbles to the top of the pen...Press the inject button...There should be a drop of insulin o [sic] the tip of the pen..." 3.1-47(a)(1) 3.1-37(a)		manufacturer's guidelines. Please see below for monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 residents, if applicable, during medication administration to assure that insulin pens are cleaned and primed appropriately in accordance with the manufacturer's guidelines. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:***	

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			2-24-23	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, observation, and interview, the facility failed to prevent the development and worsening of a pressure ulcer for a resident who was at risk for skin breakdown for 1 of 5 residents reviewed for pressure ulcers. (Resident 16) Findings include: The clinical record for Resident 16 was reviewed on 01/23/23 at 2:14 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/06/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer disease, morbid obesity, and heart failure. The resident was at risk for pressure ulcers and had one unhealed stage 2 pressure ulcer. The resident required extensive assistance of two or more staff members for bed mobility and toileting and was totally dependent on two or	F 0686	**It is the practice of this facility to assure that all residents receive the necessary care and services to prevent and treat pressure ulcers.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident 16 has preventive measures in place to prevent skin breakdown. ***Other residents that have the potential to be affected have been identified by:*** All residents that have been identified as high risk for pressure ulcers have been reviewed and preventive measures implemented appropriately.	02/24/2023

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	more staff members for transfers and dressing. Braden Scale assessments were provided by the DON (Director of Nursing) on 01/26/23 at 1:12 P.M., and included the following: - An admission assessment, dated 09/02/22, indicated the resident was completely immobile, occasionally moist, and had the potential for friction and shearing problems. - An assessment, dated 12/04/22, indicated the resident was completely immobile, constantly moist, and had friction and shearing problems. Skin Assessments were provided by the DON on 01/26/23 at 1:12 P.M., and included, but were not limited to, the following: - A weekly skin assessment, dated 11/30/22, indicated the resident had no pressure wounds. - An "Accident/Incident Skin Assessment", dated 12/01/22, was provided by the DON on 01/26/23 at 1:12 P.M. The record indicated it was a "Comprehensive skin assessment for conditions arising between week skin assessments" and the resident had developed a pressure ulcer on his right heel. No measurements were documented on the record. The "Narrative" indicated a fluid filled blister had been visualized on the resident's right heel during care. Skin Prep had been applied to the site and an air boot for pressure relief. - A weekly wound assessment, dated 12/07/22, indicated the resident had a Stage 2 (partial thickness loss of dermis presenting as a shallow ulcer with red/pink wound bed (without slough, yellow, tan, gray, green, or brown matter). May also present as an intact or open/ruptured serum		***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses have been in-serviced related to assuring that preventive measures are in place to prevent the development of pressure ulcers. In addition, the IDT will be reviewing new admissions/changes of conditions to assure that preventive measures are in place for those residents at high risk of pressure ulcers. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to review 5 residents at risk for pressure areas to assure that preventive measures are in place. The Director of Nursing, or designee, will complete this audit weekly x3, then monthly x3, then quarterly x2. Any issue identified will be immediately corrected. The Quality Assurance Committee will review the tool at regularly scheduled meetings and make additional recommendations as needed based on the outcome of the tools. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of	

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	filled blister) to his right heel that measured 3.6 cm (centimeters) x (by) 3.6 cm. The treatment was for Skin Prep (a skin toughening agent) and anti-pressure boots. - A weekly skin assessment, dated 12/21/22, indicated the wound to the right heel measured 3 cm x 2.5 cm with eschar (dead tissue). - A "Wound Evaluation Flow Sheet", dated 12/21/22, indicated the wound to the right heel was unstageable (Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar (tan, brown, or black) in the wound bed. The wound was 95% covered in necrotic (dead) tissue and the color was black. The current treatment was Skin Prep and anti-pressure boots. - A weekly skin assessment, dated 12/28/22, indicated the resident's skin was intact. The EMAR/ETAR (Electronic Medication Administration Record / Electronic Treatment Administration Record) for November and December 2022, was provided by the DON on 01/26/23 at 1:12 P.M., and included, but was not limited to, the following orders: - Monitor for behaviors, including, but not limited to aggression and resistive to care, with a start date of 09/16/22. The record indicated the resident presented with no behaviors in November or December. - Apply skin Prep to the right heel every day and night shift for pressure wound with a start date of 12/02/22, and - Air boot to right foot every day and night shift for pressure wound with a start date of 12/02/22.		residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** 2-24-23	

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	No preventative measures for the resident's heels were ordered or documented in the record prior to the development of the pressure ulcer on 12/01/22. The Progress Notes for November and December 2022, were provided by the DON on 01/26/23 at 1:12 P.M. The record lacked documentation that any preventative measures for the resident's heels were in place prior to the development of the pressure ulcer to the resident's right heel. The complete Care Plan, including resolved Care Plans, was provided by the DON on 01/25/23 at 1:45 P.M. A plan of care indicating the resident was at risk for pressure related skin breakdown related to decreased ability to off load weight on their own and they were incontinent of bowel and bladder was initiated on 09/06/22. The interventions included, but were not limited to, a pressure reducing mattress to the bed, turn and reposition every two hours, and preventative treatments as ordered. The CNA (Certified Nurse Aide) Assignment Sheets were provided by the ADON (Assistant Director of Nursing) on 01/26/23 at 9:47 A.M. Listed under "SPECIAL CARE" for Resident 16 was to keep the head of the bed elevated, two side rails up on the bed, and to turn and reposition the resident every two hours. The resident required assistance with his meals and the assistance of two staff members for care. He was to be bathed on Monday and Thursday evenings. No other preventative care measures for his heels were listed on the document. An AIMS (Abnormal Involuntary Movement Scale) assessment, dated 12/04/22, was provided by the DON on 01/26/23 at 1:12 P.M. The			

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MANDERLEY HEALTH CARE CENTER	806 S BUCKEYE ST OSGOOD, IN 47037

(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
	assessment indicated the resident had no involuntary movements to the upper or lower extremities. During an observation on 01/26/23 at 10:00 A.M., RN 2 applied Skin Prep to both of the resident's heels. Both heels were intact, and the skin was normal in color. The RN reapplied soft boots to both feet following the treatment. During an interview on 01/26/23 at 10:08 A.M., the DON indicated the CNA Assignment Sheets (pocket sheets) had resident specific care needs, altered diets, new interventions for falls, bathing days and shift, glasses, dentures, code status, and level of physical support. During an interview on 01/26/23 at 2:17 P.M., the ADON indicated the resident was bed bound and really didn't get up except for showers. The current "PRESSURE INJURY POLICY & PROCEDURE", with a reviewed date of 12/2022, was provided by the DON on 01/27/23 at 11:18 A.M., and indicated, "...It is the policy of the facility to maintain the integrity of the resident's skin, and to identify and assess residents with wounds and/or pressure ulcers, as well as those at risk for skin compromise..." The current "SKIN AND WOUND MANAGEMENT SYSTEM" policy, with a revised date of September 2022, was provided by the DON on 01/27/23 at 11:18 A.M. The policy indicated, "...Preventative intervention will be implemented for residents identified at risk..." 3.1-40(a)(1)			

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F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to adequately monitor dialysis access sites and fluid intake amounts for 3 of 3 residents reviewed for dialysis. (Residents 30, 43, 4) Findings include: 1a. Resident 30 was observed in his room on 01/24/23 at 2:42 P.M. The resident indicate he went out for dialysis on Mondays, Wednesdays, and Fridays. He had a dialysis access port on the right side of his chest. He was scheduled to have a procedure to place a permanent access port in his arm soon. The dressing on the resident's chest was clean, dry, and intact. There were no signs of infection. The resident's clinical record was reviewed on 01/27/23 at 2:26 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/22/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Parkinson's disease, diabetes, and ESRD (End Stage Renal Disease). The resident received dialysis treatment. A Care Plan, dated 02/28/22, indicated the resident had end stage renal disease with dialysis. The interventions included, but were not limited to the following:	F 0698	**It is the practice of this facility to assure proper assessment and interventions related to dialysis residents.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Residents #30 and 43 are receiving daily assessment of their dialysis site and fluid restriction orders have been discontinued per MD order. Resident 4 is receiving daily assessment of the dialysis site and receiving all medications as ordered by the physician. ***Other residents that have the potential to be affected have been identified by:*** All residents receiving dialysis have been reviewed to assure all appropriate interventions are in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted for nursing staff related assuring that dialysis sites are assessed	02/24/2023

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	- The resident had a right upper chest port. The intervention was Initiated on 02/28/22 and revised on 12/06/22. - The resident was on a 1800 ml fluid restriction. The intervention was initiated on 06/23/22 and revised on 12/06/22. - Encourage resident to follow all dietary fluid restrictions. The intervention was initiated on 02/28/22. During an interview on 01/26/23 at 1:40 P.M., LPN (Licensed Practical Nurse) 3 indicated nursing staff should monitor dialysis access sites every shift. They would look for bleeding or signs of infection. They documented their assessment of the access site on the forms they sent with the residents on the days they went out for dialysis. They did not document an assessment of the dialysis access site in the resident's clinical record on days the resident did not go out for dialysis. 1b. The resident's January 2023 EMAR (Electronic Medication Administration Record) included a current, open-ended physician's order, with a start date of 11/15/22, for an 1800 ml (milliliter) fluid restriction. The order was checked off as acknowledged twice a day, once on dayshift and once on night shift. During an interview on 01/26/23 at 1:40 P.M., LPN 3 indicated the resident was on a fluid restriction. There was no documentation of the resident's fluid intake in the clinical record. On 01/26/23 at 3:30 P.M., the ADON (Assistant Director of Nursing) provided a document, dated 12/03/22, and titled "Dietary Conformance Waiver". The document indicated the resident's		daily, fluids are monitored per if and as ordered, and medications are administered. See means of monitoring below. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly review 5 residents (if applicable) related to daily dialysis site assessment, and that medications are administered as ordered. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, then quarterly x3. Any areas identified via the audit will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes***	

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	physician placed him on a renal diet due to a diagnosis of "End Stage Renal". The resident chose to not follow the diet and to have "food/drinks" per his preference. During an interview on 01/27/23 at 11:39 A.M., the ADON indicated Resident 30 signed a waiver that indicated he did not want to comply with a fluid restriction. The resident still had an active physician's order for a fluid restriction. The facility was not monitoring the resident's fluid intake. 2a. Resident 43 was observed in his room eating snacks on 01/27/23 at 2:15 P.M. The resident indicated he had went out for dialysis earlier today. He went to dialysis on Mondays, Wednesdays, and Fridays. He had a dialysis access port on the left side of his chest. He moved his shirt revealing the port-dressing. The dressing was clean, dry, and intact. There were no signs of infection. The resident's clinical record was reviewed on 01/27/23 at 3:35 P.M. A Quarterly MDS assessment, dated 11/21/22, indicated the resident was cognitively alert and oriented. The diagnoses included, but were not limited to, hypertension, diabetes, and ESRD. The resident received dialysis treatments. A Care Plan, dated 09/13/22, indicated the resident had end stage renal disease with dialysis. The resident had a left upper chest port. The clinical record lacked documentation that an assessment of the dialysis access port was monitored on days the resident did not go out to dialysis. 2b. The resident's January 2023 EMAR included a current, open-ended physician's order, with a start		***will be completed:*** 2-24-23	

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	date of 01/07/23, for a 2000 ml fluid restriction. The order was checked off as acknowledged twice a day, once on dayshift and once on night shift. The clinical record lacked documentation of the resident's fluid intake. The current, undated facility policy, titled "Fluid Restriction", was provided by the DON on 01/27/23 at 11:18 A.M. The policy indicated, "...Fluid intake will be documented as well as compliance with prescribed restrictions..." 3a. The clinical record for Resident 4 was reviewed on 01/25/23 at 11:32 A.M. A Quarterly MDS assessment, dated 11/03/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, end stage renal disease, anemia, hypertension, diabetes, seizure disorder, anxiety, depression, and bipolar. The resident received dialysis. A Care Plan, dated 10/01/21, indicated the resident had end stage renal disease with dialysis. The resident had a left wrist fistula and right chest dialysis port. The clinical record lacked documentation that an assessment of the dialysis access port was monitored on days the resident did not go to dialysis. The current facility policy, titled "Dialysis Care Guidelines", with a reviewed on date of 09/09/14, was provided by the DON (Director of Nursing) on 01/27/23 at 11:17 A.M. The policy indicated, "...All residents receiving dialysis treatment will have their access site assessed every shift..." 3b. During an observation on 01/24/23 at 8:49 A.M., Resident 4 was sitting in her wheelchair in			

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the Activity Room. The resident was alert and oriented with no signs of discomfort.

During an interview on 01/26/23 at 10:53 A.M., RN 2 indicated the resident was alert and oriented. She was a diabetic and went out of the facility for dialysis three days a week. The resident would leave for dialysis around 10:00 A.M. and returned to the facility about 3:00 P.M. The resident did not take medications with her when she left. If she had medications that were due while she was gone, they should have been given to her when she returned.

A physician's order, dated 11/29/22 through 12/05/22 and 12/27/22 through 01/26/23, indicated the resident was to take Gabapentin 100 mg (milligrams), three times a day, for neuropathy. The December 2022 and January 2023 EMAR/ETAR indicated the resident had not received the medication due to being absent or on hold for the following dates and times:

- 12/02/22 at 2:00 P.M.,
- 12/03/22 at 2:00 P.M.,
- 12/28/22 at 2:00 P.M., Progress Noted indicated the resident was at dialysis
- 12/30/22 at 2:00 P.M.,
- 01/02/23 at 2:00 P.M.,
- 01/04/23 at 2:00 P.M.,
- 01/06/23 at 2:00 P.M.,
- 01/09/23 at 2:00 P.M.,
- 01/11/23 at 2:00 P.M.,
- 01/13/23 at 2:00 P.M.,
- 01/16/23 at 2:00 P.M.,
- 01/18/23 at 2:00 P.M.,
- 01/20/23 at 2:00 P.M., and
- 01/23/23 at 2:00 P.M.

A physician's order, dated 12/27/22 through

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	01/26/23, indicated the resident was to take insulin, 9 units with meals, three times a day for diabetes. The December 2022 and January 2023 EMAR/ETAR indicated the resident had not received the medication due to being absent or on hold for the following dates and times: - 12/28/22 at 12:00 P.M., - 12/30/22 at 12:00 P.M., - 01/02/23 at 12:00 P.M., - 01/04/23 at 12:00 P.M., - 01/06/23 at 12:00 P.M., - 01/09/23 at 12:00 P.M., - 01/11/23 at 12:00 P.M., - 01/13/23 at 12:00 P.M., - 01/16/23 at 12:00 P.M., - 01/18/23 at 12:00 P.M., - 01/20/23 at 12:00 P.M., and - 01/23/23 at 12:00 P.M. A physician's order, dated 12/27/22 through 01/26/23, indicated the resident was to take Midodrine 5 mg, three times a day, for hypotension of hemodialysis. The December 2022 and January 2023 EMAR/ETAR indicated the resident had not received the medication due to being absent or on hold for the following dates and times: - 12/28/22 at 2:00 P.M., - 12/30/22 at 2:00 P.M., - 01/02/23 at 2:00 P.M., - 01/04/23 at 2:00 P.M., - 01/06/23 at 2:00 P.M., - 01/09/23 at 2:00 P.M., - 01/11/23 at 2:00 P.M., - 01/13/23 at 2:00 P.M., - 01/16/23 at 2:00 P.M., - 01/18/23 at 2:00 P.M., - 01/20/23 at 2:00 P.M., and			

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	- 01/23/23 at 2:00 P.M. A physician's order, dated 12/27/22 through 01/26/23, indicated the resident was to take Calcium Acetate 667 mg, three times a day with meals, for end stage renal disease. The January 2023 EMAR/ETAR indicated the resident had not received the medication due to being absent or on hold for the following dates and times: - 01/04/23 at 12:00 P.M., - 01/06/23 at 12:00 P.M., - 01/09/23 at 12:00 P.M., - 01/11/23 at 12:00 P.M., - 01/13/23 at 12:00 P.M., - 01/16/23 at 12:00 P.M., - 01/18/23 at 12:00 P.M., - 01/20/23 at 12:00 P.M., and - 01/23/23 at 12:00 P.M. The clinical record lacked a physician notification of the resident not receiving the medications. The current facility policy titled "Change in Resident's Condition or Status", with a revised date of 12/16/21, was provided by the DON (Director of Nursing) on 01/26/23 at 1:12 P.M. The policy indicated, "...Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. , changes in level of care, billing/payments, resident rights, etc.)...The nurse will notify the resident's Attending Physician or physician on call when there has been a (an)...e. need to alter the resident's medical treatment significantly..." 3.1-46(a) 3.1-37(a)			

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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 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 record review and interview, the facility failed to ensure a resident's medications were available related to their diagnoses of hyperlipidemia and benign prostatic hyperplasia	F 0755	**It is the practice of this facility to assure that residents narcotics are documented and disposed of properly.**	02/24/2023

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	for 1 of 7 residents reviewed for medications. (Resident 38) Findings include: The clinical record for Resident 38 was reviewed on 01/24/23 at 10:12 AM. A Quarterly MDS (Minimum Data Set) assessment, dated 12/21/22, indicated the resident was rarely understood. The diagnoses included, but were not limited to, hyperlipidemia and benign prostatic hyperplasia. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for January 2023, was provided by the ADON (Assistant Director of Nursing) on 01/24/23 at 2:10 P.M. The EMAR included, but was not limited to the following orders: - Atorvastatin 40 mg (milligrams), one tablet by mouth one time a day for hyperlipidemia (high cholesterol). The record had a notation of "16", indicating to "See the Nurse's Notes" on the following dates: - 01/10/23, - 01/13/23, - 01/14/23, - 01/15/23, - 01/18/23, - 01/19/23, and - 01/20/23. - Tamsulosin 0.4 mg, one capsule by mouth one time a day related to benign prostatic hyperplasia. The record had a notation of "16", indicating to "See the Nurse's Notes" on the following dates:		***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident 38 is receiving medications as ordered by the physician. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed to assure that documentation of administration of the medication is reflected on the MAR appropriately and all medications are available. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses and QMA's have been in-serviced related to medication administrations. The in-service included that if the nurse/QMA identifies that a medication is not available they are to contact pharmacy following proper protocol to assure that the medication can be administered as ordered. If the medication remains unavailable the MD will be notified. See below for monitoring systems. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to randomly observe 5 residents to assure that	

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	- 01/18/23, - 01/19/23, - 01/20/23, and - 01/20/23. The Progress/Nurse's Notes were provided by the ADON on 01/24/23 at 2:10 P.M., and indicated, for the above listed dates, there was "no supply" available for these medications. The record lacked documentation the physician had been notified of the unavailability of the medications. During an interview on 01/24/23 at 1:40 P.M., LPN (Licensed Practical Nurse) 4 indicated when a resident did not have medications, they had an EDK (Emergency Drug Kit) in the medication room they could access. Not all medications were in the EDK, just general medications. If a resident had no medications in the medication cart or the EDK she would notify the MD and follow their guidance. She would document in a Progress Note if the MD was notified. During an interview on 01/24/23 at 1:46 P.M., the DON (Director of Nursing) indicated the missing medications were due to the transfer from the local pharmacy to the new company's pharmacy. During an interview on 01/24/23 at 2:23 P.M., the ADON indicated the new company took possession of the facility on 12/01/22. The current "Williams LTC (Long Term Care) Pharmacy" policy and procedure, with a reviewed date of 05/20/20, was provided by the DON on 01/26/23 at 1:12 P.M. The policy indicated, "...Preparation or administration of medication(s)...completed in accordance with physician's orders...If it is an emergency and a		medications are administered as ordered and all are available. The Director of Nursing, or designee, will complete this tool weekly x3, then monthly x3, then quarterly x3. Any areas identified via the audit or daily review will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of residents reviewed show compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** 2-24-23	

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	medication is needed after your community set cutoff please call the pharmacy and select the correct prompt...Pharmacy staff is available 24/7..." 3.1-25(a)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store food and provide a clean kitchen environment for 2 of 2 kitchen observations. This deficient practice had the potential to effect 41 of 41 residents who receive food from the kitchen. Findings include:	F 0812	**It is the practice of this facility to assure that sanitary practices are in place related to food storage and cleanliness of dietary department.** ***The correction action taken for those residents found to be affected by the deficient practice include:***	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING 00 B. WING	01/27/2023

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

(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 initial tour observation and interview on 01/23/23 at 9:39 A.M., the walk-in refrigerator contained the following: - a container of chicken noodle soup, 1/4 full, dated 12/27/22, - a 1 gallon sized, resealable storage bag with approximately four pieces of corn bread, dated 01/12/23. The Dietary Manager indicated the food should have been disposed. The dry storage room exterior walls had visible a black, dotted substance 6 to 12 inches above the base boards. During an observation and interview on 01/26/23 at 11:30 A.M., the following was observed: - A two door plastic cart contained a container of a mixture of resident boxed foods, in front of the container sat a backpack and a coat. The coat and backpack were touching the food containers, beside the coat and backpack was a box of parchment paper and a boxed roll of aluminum foil. - A rectangular vent above the coffee pot was covered in a visible layer of dust. A circular vent above the food prep table had a two foot diameter ring of visible black dust on the vent and surrounding the ceiling around the vent. - The dry storage room exterior walls had visible a black, dotted substance 6 to 12 inches above the base boards. The substance was able to be removed with the rub of a finger. The Dietary Manager indicated she was unsure what the black substance was and would get it		No specific residents were identified. The areas identified in the 2567 including disposing of food that is past the date of using, cleaning of the dry storage room walls, and cleaning of the vents above coffee maker and food prep areas have been completed. In addition, there is no employee personal items stored in the kitchen serving/storage areas. ***Other residents that have the potential to be affected have been identified by:*** All residents could potentially be affected. Please refer below to systematic changes to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All dietary staff have been in-serviced related to assuring that the areas identified in the 2567 including cleaning of dry storage room walls and cleaning of vents are cleaned in accordance with the cleaning schedule. The in-service also includes disposing of food in refrigerator once reaches expiration date and not storing employee personal items in dietary service area. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool	

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	cleaned. The circular vents should be cleaned monthly. The rectangular vent above the coffee pot was changed and cleaned by Maintenance. The Maintenance Director indicated the rectangular vent used to be cleaned monthly. The facility was recently bought by a new company and they wanted them to change and clean them every three months. He had last documented cleaning on 12/05/22. During an interview on 01/26/23 at 12:13 P.M., the Dietary Manager indicated the coat and backpack should not have been sitting on the cart. The Monthly Cleaning Schedules for December 2022 and January 2023 for the Kitchen were provided by the Administrator on 01/26/23 at 1:20 P.M. The form lacked documentation that the storage room had been cleaned in December and January. The form lacked a space for checking off that the vents had been cleaned. The current facility policy titled, "Food Storage", undated, was provided by the DON (Director of Nursing) on 01/27/23 at 11:118 A.M. The policy indicated, "...Food storage areas shall be maintained in a clean, safe, and sanitary manner. Food storage areas shall be clean at all times. Unserved leftovers shall be labeled, dated, and stored for a period not to exceed three (3) days. The current facility policy titled, "Kitchen Sanitation", undated, was provided by the DON on 01/27/23 at 11:18 A.M. The policy indicated, "...The food service area shall be maintained in a clean and sanitary manner..." 3.1-21(i)(3)		has been initiated that randomly reviews dietary to assure that the kitchen is clean including the areas identified in the 2567 and that staff are not storing personal items in serving area. The Dietary Manager, or designee, will complete this tool weekly x3, then monthly x3, then quarterly x3. Any issues identified on the Performance Improvement Tools will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools. The Quality Assurance Committee will review the Performance improvement Tool as indicated above and will increase to weekly monitoring if <90% of compliance. The Quality Assurance Committee will continue to review the Performance Improvement Tool until auditing tools are showing 100% compliance at which time the Quality Assurance Committee may decrease the monitoring increments. ***The date the systemic changes will be completed:*** 2-24-23	