STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155728	B. WING	<u>00</u>	01/31/2025	
	PROVIDER OR SUPPLIEI		806 S	T ADDRESS, CITY, STATE, ZIP COD B BUCKEYE ST DOD, IN 47037		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	This visit was for a	Recertification and State	F 0000	The facility recognizes that it n	nuet	
	Licensure Survey.	ary 27, 28, 29, 30, and 31, 2025.	r 0000	persuade your office that appropriate systems are in pla to assure ongoing compliance	ice	
	Facility number: 00 Provider number: 1 AIM number: 1002	00493 55728		the federal regulations for participation in the Medicare a Medicaid programs. Please accept the following as our process to ensure that the		
	Census Bed Type: SNF/NF: 47 Total: 47			necessary steps will be taken provide the best care possible the residents at Manderley Healthcare. Preparation and	to	
	Census Payor Type Medicare: 6 Medicaid: 40 Other: 1 Total: 47	:		execution of this plan of correct does not constitute admission agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This	or he	
	accordance with 41			plan of correction is prepared and/or executed solely because is required by the provisions of	se it	
	Quality review con	npleted on February 5, 2025.		federal and state law. Manderley Healthcare respect requests consideration of a de review for the alleged deficien within this plan of correction.	sk	
				Monica Ogden HFA		
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b) Resident Rights/E					
	interview, the facili	on, record review, and ty failed to treat a resident in a uring a meal service for 1 of 2 s. (Resident 15)	F 0550	F550 Resident Rights/Exercise of Rights/Meal service 1.Allegedly the facility failed to treat resident #15 in a dignified	,	
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

Monica Ogden LHFA 02/17/2025

Any definency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

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 disclodays 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: X7X411 Facility ID: 000493 If continuation sheet Page 1 of 23

02/20/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 01/31/2025 155728 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 806 S BUCKEYE ST MANDERLEY HEALTH CARE CENTER OSGOOD, IN 47037 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE manner during meals service. Findings include: DON/designee to provide Meal service was observed in the Main Dining education to nursing staff on the Room on 01/27/25 at 12:01 P.M. At 12:10 P.M., requirement on sit down on the Certified Nurse Aide (CNA) 6 stood upright next requirement of assistance during to Resident 15's wheelchair, to the resident's left meals. side, with the resident's head at chest height to the CNA. The CNA was saying the resident's name over and over again, to get her attention, as she spooned food into the resident's mouth. 2. Current residents that need Several empty chairs were observed in the dining assistance while eating could be room. Another staff member was sitting down in a affected by this alleged practice. chair, at the same table, assisting another resident The Director of with their meal. CNA 6 continued to stand over Nursing/designee/Administrator Resident 15 while she assisted the resident with completed an audit of all residents her meal until 12:36 P.M. needing assistance while eating to ensure proper seating for staff. The clinical record for Resident 15 was reviewed DON/designee to provide on 01/28/25 at 1:29 P.M. A Quarterly Minimum education to nursing staff on the Data Set (MDS) assessment, dated 01/15/25, requirement on sit down on the indicated the resident was moderately cognitively requirement of assistance during impaired. The resident's diagnoses included, but meals. were not limited to, diabetes, hypertension, dementia, anxiety, depression, and psychotic disorder. The resident was dependent on staff for assistance with eating. 3. Director of Nursing/Designee/Administrator During an interview on 01/30/25 at 10:05 A.M., completed an in-service with the CNA 4 indicated when assisting a resident with facility staff regarding Resident

their meal, they would apply a clothing protector to the resident, pull up a chair, sit down next to the resident, and assist them with eating their meal.

The current "Resident Rights" policy, with a revised date of June 2023, was provided by the Director of Nursing (DON) on 01/30/25 at 10:25 A.M. The policy indicated, "...Employees shall treat all residents with kindness, respect, and

Rights including treating all residents with kindness, respect and dignity including while sitting next to resident while assisting them in eating their meal.

4. Director of Nursing/Designee/Administrator

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

PRINTED: 02/20/2025 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155728	B. WI	NG		01/31/	/2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MANDED		NE OENTED			BUCKEYE ST		
MANDER	RLEY HEALTH CAR	RE CENTER		OSGOC	DD, IN 47037		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	dignity"				will audit current residents tha	t t	
					need assistance with eating to		
	3.1-3(a)				ensure staff are sitting while		
	,				assisting in eating as follows:		
					Residents needing assistand	:e	
					audit 5 meals per week x 4	· ·	
					weeks, 3 meals per day x 4		
					weeks, then 1 meal per week	x 16	
					weeks. Any identified concern		
					will be immediately addressed		
					This will continue for no less the		
					6 months and compliance is m		
						ict.	
					The Director of Nursing/Desig	nnaa	
					will present the results of thes	-	
					reviews will be immediately	-	
					reported if concerns exist and	will	
					be discussed at the monthly	VVIII	
					Quality Assurance Committee		
					meeting monthly for 6 months		
					then quarterly thereafter once		
					compliance has been achieve		
					a total of 6 months of monitori	-	
					Re-education, frequency and/	ונ	
					duration of reviews will be	-6	
					increased as needed, if areas	Of	
					noncompliance are identified	•	
					through the auditing process.	-	
					patterns that are identified will		
					have an Action Plan initiated.		
					QAPI committee will determine	Э	
					when 100% compliance is		
					achieved or if ongoing monitor	ring	
					is required.		

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Event ID:

X7X411

Facility ID: 000493

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		X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00 COMPLE		
		155728	B. W	ING		01/31/	2025
	PROVIDER OR SUPPLIER			806 S E	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST DD, IN 47037		
(X4) ID	SUMMARY S	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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
F 0583 SS=D Bldg. 00	-	Confidentiality of Records					
		on, record review, and	F 0:	583	F583 Personal		02/21/2025
		ty failed to maintain resident manner related to information			Privacy/Confidentiality of		
		er screen and on top of a			Records Open Screen		
	•	2 of 6 random observations.					
	(100 and 300 Hall N				1Hall 100 & 300 medication o	art	
	Findings include:				screen was allegedly left unattended along with a repor sheet laying on top of this cart	t	
	During a continuo	ous observation on 01/27/25			and an empty medication card		
		:39 P.M., the 100 Hall			top of the cart for residents 27		
	Medication Cart wa	s left unattended. Resident			249 by the deficient practice.		
	249's information w	ras visible on the screen,			Employee #3 and #8 was educated during the survey		
	- On 01/27/25 at 2:1	7 P.M., two Certified Nurse			process.		
	Aides (CNA) walke	ed by the medication cart.					
		23 P.M., The computer screen					
	on the medication ca	art remained unattended.			2 Current residents, if the medication cart was left		
	- On 01/27/25 at 2:2	25 P.M., two CNAs walked by			unattended with screen open,		
	the medication cart.				empty med card and along wit report sheet, have the potentia		
	- On 01/27/25 at 2:2	28 P.M., a CNA walked by the			be affected by the alleged def		
	medication cart.	.,			practice. The Director of Nursi		
					/Designee completed an audit	•	
	- On 01/27/25 at 2:3	31 P.M., RN 3 walked to the			all medication carts for		
	medication cart, ma	de some notes on a piece of			compliance on proper policy o	f	
	* *	eack to the nurse's station			privacy & confidentiality of		
	without closing the	computer screen.			resident's records including computer screens. DON/Design	anee	
	- On 01/27/25 at 2:3	33 P.M., a Laundry Aide walked			will provide education to nursi	-	
	by the medication ca	art.			staff who pass medication on	the	
	On 01/27/25 -4 2 3	OODM two CNA 1 -			requirement to protect residen		
		88 P.M., two CNAs and a			data when passing medication	1.	
	Launury Aide Walke	ed by the medication cart.					

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155728	B. WING		01/31/2025	
		1	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R		BUCKEYE ST		
MANDEF	RLEY HEALTH CAF	RE CENTER		OD, IN 47037		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	ID	<u> </u>	(V5)	
PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
0		ion and interview on 01/27/25	1710		Dille	
at 2:39 P.M., RN (3) approached the medication			3 The Director of			
	cart and indicated the Qualified Medication Aide			Nursing/Designee/Administrator		
	was passing medica	ations that shift. The computer		held an in-service with all lice		
	screen should have	been locked when left		nursing staff and QMA's relate	ed to	
	unattended.			policy of confidentiality of		
				information and personal priva	асу.	
	•	tion there were mobile				
		neral area three to five feet of				
	the medication cart					
	~	nous observation on 01/29/25		4 The Director of		
		o 10:45 A.M., the medication cart		Nursing/Designee will audit		
		aying on the top of the cart and		medication carts to ensure the screens are closed and		
	_	t names listed with resident		confidential records are left		
		ext to each name. A stack of		unattended as follows: 5 carts	ner	
		cards were on top of the cart		week x 4 weeks, 3 carts per w	· ·	
		ent 27 lying on the top of the		x 4 weeks, 1 cart per week x		
		e standing in the immediate		weeks. Any identified concer		
		veral staff members and an		will be immediately addressed		
	independently mob	ile resident using a walker		This will continue for no less t		
	walked next to the	cart during the observation		6 months and compliance is n	net.	
	time period.					
	0.01/00/05	20.4.14				
		39 A.M., two staff members		The Dissets (N. 1. 75. 1		
	walked past the me	cuication cart,		The Director of Nursing/Designation		
	_ On 01/20/25 at 10):39 A.M., a staff member walked		will present the results of thes	e	
		cart carrying clean linens,		reviews will be immediately reported if concerns exist and	will	
	past the medication	contraintying crean inicia,		be discussed at the monthly	VVIII	
	- On 01/29/25 at 10	0:40 A.M., a staff member walked		Quality Assurance Committee		
	past the medication			meeting monthly for 6 months		
	•	•		then quarterly thereafter once		
	- On 01/29/25 at 10):40 A.M., a QMA walked past		compliance has been achieve		
	the medication cart			a total of 6 months of monitori		
				Re-education, frequency and/	or	
		3:41 A.M., a staff member walked		duration of reviews will be		
	past the medication	ı cart,		increased as needed, if areas	of	
				noncompliance are identified		

- On 01/29/25 at 10:41 A.M., another staff member

through the auditing process. Any

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155728	B. W	ING		01/31/	2025
	PROVIDER OR SUPPLIER		<u> </u>	806 S B	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST DD, IN 47037		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	walked past the med	dication cart,			patterns that are identified will		
	independently mobi past the medication	:42 A.M., Resident 9, who was ile with their walker, walked cart, and :45 A.M., a QMA walked up to			have an Action Plan initiated. QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required.	Э	
		earing off the portion of the					
	_	ontaining the residents' names.					
	During an interview QMA 8 indicated not the medication carts. The current "Confider Personal Privacy" properties and Privacy properties and privacy properties. The facility resident's privacy retreatmentpersonal personal and medicated privacy	on 01/29/25 at 11:18 A.M., othing should be left on top of s with resident names visible. Identiality of Information and solicy, with a revised date of ded by the Director of Nursing at 10:25 A.M. The policy cility will protect and confidentiality and personal dent personal and medical y will strive to protect the garding his or hermedical careAccess to resident al records will be limited to business associates"					
F 0684 SS=D Bldg. 00	483.25 Quality of Care						
3.00	failed to follow the hold parameters for	riew and interview, the facility physician's orders related to medications for 2 of 15 for Quality of Care. (Residents	F 00	584	F 684 Quality of Care 1 Resident #15 & 24 was allegedly affected by the defici practice. Resident #15 heart rate & #24		02/21/2025
	Findings include:				blood pressure parameters reviewed by facility Nurse		

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Event ID:

X7X411

Facility ID: 000493

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	T OF PEFICIENCIES	· · · · · · · · · · · · · · · · · · ·	770)) G == ==============================	NOTELICATION	ONIB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155728	B. WING		01/31/2025
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST	
MANDE	RLEY HEALTH CAF	RE CENTER		OD, IN 47037	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		rd for Resident 15 was reviewed		Practitioner and new order	
	on 01/28/25 at 1:29	P.M. A Quarterly Minimum		received to d/c parameters.	
	1 1	sessment, dated 01/15/25,			
	indicated the reside	nt was moderately cognitively			
	impaired. The resid	ent's diagnoses included, but		2 Current residents receiving	g
	were not limited to,	coronary artery disease,		blood pressure and heart rate	
	diabetes, and hyper	tension.		medications and having	
				parameters for administration I	nave
	A current open-end	ed physician's order, with a		the potential to be affected by	the
	start date of 09/05/2	24, indicated the resident was		alleged deficient practice and a	any
	to take Coreg (a car	diac medication) 25 milligrams		identified concerns were	
	(mg), two times a d	ay related to hypertensive		immediately addressed and ne	ew
	heart disease. The r	nedication was to be held (not		orders followed as provided by	the
	given) for a Heart F	Rate (HR) of less than or equal		facility Nurse Practitioner. A 10	00%
	to 60 beats per min	ute and/or a blood pressure		audit of current residents recei	ving
	less than or equal to	0 110/50.		blood pressure and heart rate	
				medications and having param	eter
	The current Octobe	r 2024, December 2024, and		for administration has been	
	January 2025, Elect	tronic Medication		completed by the Director of	
	Administration Rec	ord (EMAR) for the resident's		Nursing and reviewed with the	
	Coreg was provided	d by the Director of Nursing		facility Nurse Practitioner. Any	• • • • • • • • • • • • • • • • • • •
	(DON) on 01/30/25	at 1:29 PM., and indicated the		identified concerns were	
	resident had receive	ed the Coreg medication when		immediately addressed and ne	ew
	the resident's HR w	as less than or equal to 60 for		orders followed as provided by	• • • • • • • • • • • • • • • • • • •
	the following dates	and times:		facility Nurse Practitioner.	
				3 The Administrator and	
	- 10/02/24 at bedtin	ne the HR was 57,		Director of Nursing held an	
	- 10/03/24 at 7:00 A	A.M. the HR was 60,		in-service with licensed nurses	;
	- 10/04/24 at bedtin	ne the HR was 60,		regarding "Administering	
	- 10/06/24 at 7:00 A	A.M., the HR was 60,		Medication" as it relates to	
		A.M., the HR was 60,		following hold parameters for b	olood
		A.M., the HR was 60,		pressure medications.	
	- 10/09/24 at bedtin			<u> </u>	
	- 10/11/24 at bedtin				
	- 10/12/24 at bedtin				
		A.M., the HR was 60,		4 The Director of	
	- 10/13/24 at bedtin			Nursing/Designee will audit	
		A.M., the HR was 60,		resident's receiving heart rate	and
	- 10/15/24 at bedtin			blood pressure medications wi	• • • • • • • • • • • • • • • • • • •
		A.M., the HR was 60,		parameters to ensure paramet	
	1	,,	i		i

PRINTED: 02/20/2025 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL		
		155728	B. WING		01/31/		
		1					
NAME OF I	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST			
MANDER	RLEY HEALTH CAF	RE CENTER		OD, IN 47037			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE	
		A.M., the HR was 60,		are being followed. The audit	will		
		A.M., the HR was 60,		be completed as follows: 5	••••		
	- 10/24/24 at bedtin			residents with parameters x 4			
		A.M., the HR was 55,		weeks, then 3 residents with			
	- 10/29/24 at bedtin			parameters x 4 weeks, then 1			
		A.M., the HR was 60,		resident with parameters x 16			
	- 12/04/24 at bedtin			weeks. Any identified concer			
	- 12/05/24 at bedtin			will be immediately addressed			
		A.M. the HR was 60,		This will continue for no less t			
	- 12/06/24 at bedtin			6 months and compliance is n			
		A.M., the HR was 60,					
		A.M., the HR was 60,		The Director of Nursing/Design	nee		
		A.M., the HR was 60,		will present the results of thes	-		
		A.M., the HR was 60,		reviews will be immediately			
	- 12/14/24 at bedtin			reported if concerns exist and	will		
	- 12/16/24 at bedtin			be discussed at the monthly			
	- 12/17/24 at bedtin			Quality Assurance Committee	;		
	- 12/20/24 at bedtin			meeting monthly for 6 months			
	- 12/21/24 at bedtin	ne the HR was 60,		then quarterly thereafter once			
	- 12/22/24 at 7:00 A	A.M., the HR was 60,		compliance has been achieve			
	- 12/24/24 at bedtin			a total of 6 months of monitori			
	- 12/25/24 at 7:00 A	A.M., the HR was 60,		Re-education, frequency and/	-		
	- 12/26/24 at 7:00 A	A.M., the HR was 60,		duration of reviews will be			
	- 12/27/24 at bedtin	ne the HR was 60,		increased as needed, if areas	of		
	- 12/28/24 at 7:00 A	A.M., the HR was 60,		noncompliance are identified			
		A.M., the HR was 60,		through the auditing process.	Any		
	- 01/01/25 at 7:00 A	A.M., the HR was 60,		patterns that are identified will	-		
	- 01/04/25 at 7:00 A	A.M., the HR was 60,		have an Action Plan initiated.			
	- 01/06/25 at bedtin	ne the HR was 60,		QAPI committee will determin	е		
	- 01/07/25 at 7:00 A	A.M., the HR was 60,		when 100% compliance is			
	- 01/08/25 at 7:00 A	A.M., the HR was 60,		achieved or if ongoing monito	ring		
	- 01/14/25 at 7:00 A	A.M., the HR was 60,		is required.	=		
	- 01/14/25 at bedtin	ne the HR was 60,					
	- 01/15/25 at 7:00 A	A.M., the HR was 60,					
	- 01/15/25 at bedtin						
	- 01/17/25 at 7:00 A	A.M., the HR was 60,					

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- 01/19/25 at bedtime the HR was 60, - 01/21/25 at 7:00 A.M., the HR was 60, - 01/23/25 at 7:00 A.M., the HR was 60, - 01/25/25 at bedtime the HR was 60, and

Event ID:

X7X411

Facility ID: 000493

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155728	B. W	ING	_	01/31	/2025
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			BUCKEYE ST		
MANDEF	RLEY HEALTH CAF	RE CENTER	_	osgoo	DD, IN 47037		
(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 APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	- 01/2//25 at /:00 F	A.M., the HR was 60.					
	The Consultant Pha	armacist's Medication Regime					
		October and December 2024,					
		ne DON on 01/30/25 at 1:45					
	P.M., and indicated						
		-					
		pharmacist indicated there were					
		reg medication should have					
		e resident's HR. This was not					
		n on the Medication					
		ord (MAR). Please educate the					
	staff, and						
	- On 12/18/24 the i	pharmacist indicated there were					
		reg medication should have					
		e resident's HR. This was not					
	documented as such	n and to please educate the					
	staff.						
	During an interview	v on 01/30/25 at 10:40 AM., the					
	_	received the pharmacy					
	recommendations v	when they came in. Once they					
		give the Nurse Practitioner					
	` ′	dations designated for the					
		es designated for nursing, she					
		n. Pharmacy recommendations					
	1	and the middle of the month.					
	one tried to have th	em addressed within 30 days.					
	The Care Plan for t	he resident being at risk for a					
		d to hypertension and					
		ease was provided by the DON					
		P.M. The interventions					
	included, but were	not limited to, monitor vital					
	signs as ordered.						
	2. The clinical reco	rd for Resident 24 was reviewed					
		5 A.M. A Quarterly MDS					
		2/10/24, indicated the resident					
I	L was comitively into	act. The resident's diagnoses	1		l		Ī

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	UILDING	nstruction 00	(X3) DATE COMPL 01/31/	ETED
	PROVIDER OR SUPPLIEF		806 S B	DDRESS, CITY, STATE, ZIP COD UCKEYE ST DD, IN 47037		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ORRECTIVE ACTION SHOULD BE	
TAG		R LSC IDENTIFYING INFORMATION not limited to, hip and knee	TAG	DEFICIENCY)		DATE
		tension, anxiety, depression,				
	01/23/25, indicated Midodrine 10 mg, t pressure. The staff when the resident's number was greater	the resident was to take hree times a day for low blood were to hold the medication systolic blood pressure (top) than 110 or the diastolic blood imber) was greater than 70.				
	start date of 01/23/2 to take Midodrine 1 pressure. The staff when the resident's	ed physician's order, with a 25, indicated the resident was 0 mg, with meals for low blood were to hold the medication systolic blood pressure than 110 or the diastolic blood or than 70.				
	January 2025 EMA received the Midod systolic blood press	ber and December 2024 and R indicated the resident had rine when the resident's sure was greater than 110 or eater than 70 for the following				
	114/67, - 11/09/24 at bedtin 120/61, - 11/14/24 in the management of the manageme	ne when the blood pressure was ne when the blood pressure was borning when the blood pressure was borning when the blood pressure was borning when the blood pressure borning when the blood pressure				
		orning when the blood pressure				

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Event ID:

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	OF CORRECTION	IDENTIFICATION NUMBER 155728	r í	JILDING	00	COMPL 01/31/	ETED
	PROVIDER OR SUPPLIER			806 S B	DDRESS, CITY, STATE, ZIP COD UCKEYE ST DD, IN 47037		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
IAU	was 114/60, - 12/16/24 in the mowas 114/68, - 12/20/24 at bedtin 115/80, - 12/25/24 at midda 115/78 and at bedtin was 110/82, - 01/01/25 at bedtin 127/88, - 01/04/25 in the mowas 112/75, - 01/05/25 at bedtin 116/75, - 01/08/25 in the mowas 102/72, - 01/10/25 at bedtin 123/79, - 01/13/25 in the mowas 102/72 and at bedrin 123/79, - 01/13/25 at bedtin 115/69, - 01/17/25 at bedtin 111/74, and - 01/22/25 at bedtin 119/80. During an interview 2 indicated if a med then she would obta and if the vitals were parameters, then she the vitals were not would not administed document why the radministered. The current facility	orning when the blood pressure was me when the blood pressure was me when the blood pressure was brining when the blood pressure was be when the b		TAG			DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155728	B. W	ING	_	01/31/	/2025
NAME OF T	DOLUBER OF CURRY			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t .			BUCKEYE ST		
MANDER	RLEY HEALTH CAR	RE CENTER		osgoo	OD, IN 47037		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	-	by the DON on 01/30/25 at cy indicated, "Medications					
	_	ed in a safe and timely manner,					
		The following information					
	_	rified for each resident prior to					
		cations:Vital signs, if					
	necessary"						
	3.1-37(a)						
F 0690	483.25(e)(1)-(3)						
SS=D Bowel/Bladder Incontinence, Catheter, UTI							
Bldg. 00		,					
-	Based on record rev	view and interview, the facility	F 0	590	F690 B&B Inc,		02/21/2025
		nary Tract Infection (UTI) in a			1 Resident #1 was allegedly	/	
	-	of 2 residents reviewed for			affected by the deficient practi	ce	
	UTIs. (Resident 1)						
					Resident #1 U/A was ordered		
	Findings include:				obtained and results of U/A ar		
	The eliminal manned	for Resident 1 was reviewed on			failed to treat a UTI in a timely		
		M. An Admission Minimum			manner.		
		t, dated 11/07/24, indicated the					
		ly cognitively impaired. The					
		s included, but were not			2 Current residents with or	ders	
		n's disease, dementia, aortic			for U/A have the potential to b		
	valve disorder, urin				affected by the alleged deficie		
	hypertension.				practice. The physician will be		
					notified if any U/A are not		
	_	ted 11/02/24 (Saturday) at			completed if identified.		
		ed new physician's orders were					
		Urinalysis and Culture and			The Director of Nursing/Design	•	
	Sensitivity (UA/CS)	<i>)</i> .			completed a 30 day look back		
	A Nursing Note de	ted 11/03/24 (Sunday) at 8:38			current residents with U/A order		
	_	resident denied pain or			to ensure completion as order Any identified concerns were	c u.	
		erienced frequent incontinent			immediately addressed.		
	_	ent feelings of needing to void.			miniodiatory addressed.		
	The resident's urine				3 The Administrator/Director	or of	
		C			Nursing held an in-service with		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED
		155728	B. W	VING		01/31/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF F	PROVIDER OR SUPPLIEF	8			BUCKEYE ST	
MANDEF	RLEY HEALTH CAF	RE CENTER			OD, IN 47037	
	Г				· 	OVE
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
TAG) report for the urinalysis	+	TAU	licensed nurses regarding	DATE
		nt's urine was collected on			"Physician Services" related to	
					U/A and treating in timely mar	
	11/06/24 (Wednesday) and the results were reported on 11/08/24 (Friday).			on tand a caung in union manner.		
	reported on 11/06/24 (1 iiday).					
	The report indicated	d the following bacteria were				
	detected in the sam	_			4 The Director of	
		-			Nursing/Designee will review	U/A
	- Klebsiella pneumo	oniae, with an estimated high			orders received for current	
	microbial load,				residents, the physician/NP no	ote,
	1	lii/braak/koseri, with an			and order entered for accurac	
	estimated moderate	microbial load,			follows: 5 residents per week	-
	- Proteus mirabilis,	with an estimated moderate			weeks, then 3 residents per w	reek
	microbial load,				x 4 weeks, then 1 resident pe	r
	- Pseudomonas aeru	aginosa, with an estimated			week x 16 weeks. Any identifi	ed
	moderate microbial	load,			concerns will be immediately	
	- Actinobaculum sc	haalii, with an estimated low			addressed. This will continue	for
	microbial load,				no less than 6 months and	
	- Enterobacteriacea	e, with an estimated low			compliance is met.	
	microbial load, and					
		calis, with an estimated low			The Director of Nursing/Design	-
	microbial load.				will present the results of thes	e
					reviews will be immediately	
		ended potential antibiotics to			reported if concerns exist and	will
	treat the bacteria.				be discussed at the monthly	
	A 3.7	. 111/11/04/05 1 1 2 2 2 2			Quality Assurance Committee	
		ated 11/11/24 (Monday) at 3:31			meeting monthly for 6 months	l l
		ew physician's order was			then quarterly thereafter once	
		ster Fosfomycin (an antibiotic),			compliance has been achieve	l l
	5 milligrams every	72 hours for three doses.			a total of 6 months of monitori	_
	A Nivesia - Ni-4- 1	tod 11/11/24 at 4.10 D.M			Re-education, frequency and/	or
	_	ated 11/11/24 at 4:10 P.M.,			duration of reviews will be	of
		y requested the pharmacy to			increased as needed, if areas	OI
	SIAI (immediate)	send the Fosfomycin packet.			noncompliance are identified	Amy
	A Shift I areal A decay	inistration Note, dated 11/11/24			through the auditing process.	-
		ated the resident received first			patterns that are identified will	
	dose of the antibiot				have an Action Plan initiated.	
	uose of the antibiot	ic to treat her U11.			QAPI committee will determin	e
	Duning a gar intern	or on 01/21/25 of 11:12 A M 41			when 100% compliance is	
	During an interview	v on 01/31/25 at 11:12 A.M., the			achieved or if ongoing monito	ring

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155728		A. BU	A. BUILDING <u>00</u>			3) DATE SURVEY COMPLETED 01/31/2025	
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037				
(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 APPROPRIA' DEFICIENCY)	ГЕ	(X5) COMPLETION DATE
F 0761 SS=D Bldg. 00	Director of Nursing results were available could contact the phand get an antibiotic. The current "Physic revised date of 03/1 DON on 01/30/25 a indicated, "The facarry out the orders accordance with all guidelines" 3.1-41(a)(2) 3.1-49(a) 483.45(g)(h)(1)(2) Label/Store Drugs Based on observation failed to store medication carts revisited to store medication carts revisited failed to store medication carts revisited to 2:17 P.M. to 2:39 P. Cart was unlocked at - On 01/27/25 at 2:	and Biologicals on and interview, the facility cations appropriately for 1 of 2 riewed. (100-Hall Medication s observation on 01/27/25 from M., the 100-Hall Medication	F 0	761		ded ne	DATE 02/21/2025
	- On 01/27/25 at 2:2 remained unlocked - On 01/27/25 at 2:2 the medication cart,	23 P.M., The medication cart and unattended, 25 P.M., two CNAs walked by			2 Current residents, if the medication cart was left unlock have the potential to be affected by the alleged deficient practice. The Director of Nursi	ed ng	
	- On 01/2//25 at 2:2	8 P.M., a CNA walked by the			/Designee completed an audit	UI	

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
155728		B. WING 01/31/2025					
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	medication cart, - On 01/27/25 at 2:31 P.M., RN 3 walked to the			all medication carts for compliance on proper policy labeling and storage of			
		de some notes on a piece of			medications. DON/designee		
		back to the nurse's station			provided education to nursing	staff	
	without locking the	medication cart,			on the requirement to secure		
	- On 01/27/25 at 2:33 P.M., a Laundry Aide walked by the medication cart, and				medication and treatments by locking medication storage areas.		
		88 P.M., two CNAs and a					
	Laundry Aide walked by the medication cart.						
	at 2:39 P.M., RN 3 and indicated the Q (QMA) had been pa	approached the medication cart ualified Medication Aide assing medications this shift.			3 The Director of Nursing/Designee/Administrat held an in-service with all licer nursing staff and QMA's relate policy of labeling and storage medications.	nsed ed to	
	During the observation there were mobile residents in the general area three to five feet of the medication cart. The current facility policy, titled "Storage of Medications", with a revision date of April 2007, was provided by the Director of Nursing (DON) on 01/30/25 at 10:25 A.M. The policy indicated, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner" 3.1-25(o)				4 The Director of Nursing/Designee will audit medication carts on proper po of labeling and storage of medication to ensure carts are locked as follows: 5 carts per week x 4 weeks, 3 carts per w x 4 weeks, 1 cart per week x 1 weeks. Any identified concer will be immediately addressed This will continue for no less the 6 months and compliance is m The Director of Nursing/Desig will present the results of these reviews will be immediately reported if concerns exist and be discussed at the monthly	reek 16 ns I. han het. gnee	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/20/2025 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
155728		B. W	NG		01/31/	/2025	
				CTREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			BUCKEYE ST		
MANDEE	RLEY HEALTH CAF	DE CENTED			OD, IN 47037		
IVIAINDER	KLET HEALTH CAP	RE CENTER		USGU	JD, IN 47037		
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Quality Assurance Committee		
					meeting monthly for 6 months	and	
					then quarterly thereafter once	full	
					compliance has been achieved	d for	
					a total of 6 months of monitorii	ng.	
					Re-education, frequency and/o	or	
					duration of reviews will be		
					increased as needed, if areas	of	
					noncompliance are identified		
					through the auditing process.	Any	
					patterns that are identified will		
					have an Action Plan initiated.	The	
					QAPI committee will determine	е	
					when 100% compliance is		
					achieved or if ongoing monitor	ing	
					is required.	•	
					·		
F 0770	483.50(a)(1)(i)						
SS=D	Laboratory Servic	es					
Bldg. 00							
	Based on interview	and record review, the facility	F 07	770	F770 Laboratory Services		02/21/2025
	failed to obtain a bl	ood test and a urinalysis for 1			1 Resident #1 was allegedly	/	
	of 5 residents review	wed for laboratory services.			affected by the deficient practi	ce.	
	(Resident 1)						
					Resident #1 validated to have	e a	
	Findings include:				lab requisition in place per MD)	
					order for Thursday lab draws.		
	1a. The clinical reco	ord for Resident 1 was reviewed					
	on 01/28/25 at 2:10	P.M. An Admission Minimum					
	Data Set assessmen	t, dated 11/07/24, indicated the					
	resident was severe	ly cognitively impaired. The			2 Residents with lab orders	;	
	resident's diagnoses	s included, but were not			have the potential to be affected	ed	
	limited to, Parkinso	n's disease, dementia, and			by the alleged deficient practic		
	aortic valve disorde	r.					
					The Director of Nursing /Design	gnee	
	The resident's Nove	ember 2024 physician's orders			completed audit of the last 60		

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The resident's November 2024 physician's orders included, but were not limited to, the following:

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days to ensure ordered labs were

completed for current

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155728		B. WING 01/31/2025				2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					BUCKEYE ST		
MANDEF	RLEY HEALTH CAF	RE CENTER			OD, IN 47037		
(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 APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		tart date of 11/02/24, to			residents. The physician will b		
		(an anticoagulant) medication.		notified of any missed lab orders if			
		receive 3.5 milligrams (mg),			identified.		
	1 .	dnesday, Thursday, Saturday,					
	I -	ng every Tuesday and Friday,					
	and						
	A 1 1.1	1			3 The Administrator/Director		
	· ·	tart date of 11/07/24, to obtain			Nursing held an in-service with		
		a blood test that measured how			licensed nursing staff related t	.o	
	long it took for a bl	ood sample to clot).			"Lab and Diagnostic Test		
	A Numair a Mata 1-	tod 11/07/24 at 4.51D M			Results-Clinical Protocol" related	iea	
	A Nursing Note, dated 11/07/24 at 4:51P.M., indicated the laboratory (lab) technician had an expired sample collection tube and would have to obtain the blood sample on 11/08/24.				to obtaining ordered labs.		
	ootani tiic olood sai	inpic on 11/06/24.			4 The Director of		
	A Nursing Note da	ted 11/11/24 at 2:56 P.M.,			Nursing/Designee will audit cu	ırrent	
	_	as unable to collect the PT/INR			residents with lab orders for		
		, 11/08/24, or 11/09/24. The			completion as ordered as follo	ws.	
		the lab, and they were going to			5 residents per week x 4 week		
		STAT (immediate) PT/INR.			residents per week x 4 weeks		
		,			resident per week x 16 weeks		
	The lab report for the	ne PT/INR blood test indicated			Any identified concerns will be		
		ected on 11/21/24 and resulted		immediately addressed. This will			
	_	sults were within the		continue for no less than 6 months			
	recommended thera	peutic range for the resident.			and compliance is met.		
	A Nursing Note, da	ted 11/22/24 at 11:22 A.M.,					
	indicated the Nurse	Practitioner was updated on					
	the PT/INR results.	The resident was to continue			The Director of Nursing/Design	gnee	
	the current dose of	warfarin.			will present the results of thes	е	
					reviews will be immediately		
	_	on 01/31/25 at 11:12 A.M., the			reported if concerns exist and	will	
	~	(DON) indicated the lab said			be discussed at the monthly		
	1	a sample from the resident so			Quality Assurance Committee		
		for a STAT PT/INR on			meeting monthly for 6 months		
	_	ole was collected by the lab on			then quarterly thereafter once		
		ed on 11/22/24. She would have			compliance has been achieve		
	liked to have had th	e lab drawn before 11/21/24.			a total of 6 months of monitori	-	
					Re-education, frequency and/	or	

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Facility ID: 000493

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155728		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/31/2025					
	ROVIDER OR SUPPLIER		806 S E	STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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				
TAG	1b. A Nursing Note 11:51 P.M., indicate received to obtain a Sensitivity (UA/CS) A Nursing Note, da A.M., indicated the discomfort but experience and frequently and the resident's urine and the sample was of refrigerator. The laboratory (lab) indicated the resident and the resident and the resident and the resident and the sample was of refrigerator. The laboratory (lab) indicated the resident and the report and the sample was of refrigerator. The laboratory (lab) indicated the resident and	dated 11/02/24 (Saturday) at ed new physician's orders were Urinalysis and Culture and for Resident 1. Ited 11/03/24 (Sunday) at 8:38 resident denied pain or brienced frequent incontinent and feelings of needing to void. The had a strong odor. Inistration Note, dated 11/04/24 a.M., indicated the resident's obtained and placed in the preport for the urinalysis and the results were at (Friday). If the following bacteria were bele: In the following bacteria were bele: In the following bacteria were belee: In the following bacteria were bele: In the following bacteria were belee: In the following bacteria were belee:	TAG	duration of reviews will be increased as needed, if areas noncompliance are identified through the auditing process. patterns that are identified will have an Action Plan initiated. QAPI committee will determin when 100% compliance is achieved or if ongoing monitor is required.	Any I The				
	- 1.5 1.5 port recommi	potential annotones to							

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155728		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2025				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	A Nursing Note, da P.M., indicated a ne received to adminis 3 milligrams every During an interview 2 indicated the lab of Thursdays, Fridays, had a urine specime any other time the final didn't come to the sample. If the sample and consample. If the sample didn't come to the ship the sample out company was located. The current "Lab are Clinical Protocol" of September 2012, where the sample and consample and company was located. The current "Lab are Clinical Protocol" of September 2012, where the sample and consample are company was located. The current "Lab are Clinical Protocol" of September 2012, where the sample are clinical Protocol of the current "Lab are Clinical Protocol" of September 2012, where the sample are clinical Protocol of the current will be sample and the current will be sample and the current will be company to the current will be sample and the current will be sampl	ted 11/11/24 (Monday) at 3:31 by physician's order was ter Fosfomycin (an antibiotic), 72 hours for three doses. You on 01/30/25 at 9:25 A.M., RN would pick up specimens on and Saturdays. If the facility in that needed to be sent out at facility would have to ship it. You on 01/31/25 at 11:12 A.M., the sing staff were to collect the intact the lab to pick up the le was collected on a day the ine facility, they would have to a She was unsure where the lab bed. Ad Diagnostic Test Results - with a revision date of as provided by the DON on M. The policy indicated, "The ify, and order diagnostic and diagnostic and monitoring ll process test requisitions and						
	3.1-49(a)							
F 0812 SS=D Bldg. 00	Based on observation failed to store foods	e/Prepare/Serve-Sanitary on and interview, the facility in a sanitary manner related	F 0812	F812 Food Storage	02/21/2025			
		tdated foods for 1 of 3 kitchen leficient practice had the		1Allegedly the facility failed to	o			

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X7X411

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 01/31/2025 155728 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 806 S BUCKEYE ST MANDERLEY HEALTH CARE CENTER OSGOOD, IN 47037 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE potential to affect 45 of 47 resident that receive store food in a sanitary manner food from the kitchen. related to unlabeled and outdated foods which had the potential to Findings include: affect 45 of 47 residents. 1/2 full half gallon of lactose free 2% milk, During the initial tour of the facility kitchen on unopened half gallon of lactose 01/27/25 at 10:35 A.M., the following items were free 2% milk and 1/3 pan full of observed: gravy was outdated and discarded. - A 1/2 full half gallon of lactose free 2% milk that 2 The lactose free 2% milk was expired on 01/21/25, replaced, and a complete audit was done to ensure no other food - An unopened half gallon of lactose free 2% milk items were outdated. that expired on 01/21/25, and - A metal pan 1/3 full of brown gravy. The pan was covered with plastic wrap and dated 01/21/25. 3 Administrator/Dietary Manager completed an in-service with During an interview on 01/27/25 at 10:40 A.M., dietary staff regarding labeling of Cook 5 indicated the milk and brown gravy were food and discarding of food after 3 expired and should have been thrown out. days. The current facility policy, titled "Policy: Storage Areas", dated 07/2023, was provided by the Director of Nursing on 01/30/25 at 10:25 A.M. The 4 The Dietary Manager/designee policy indicated, "...Leftover food is used within 3 will audit the stored food and days or discarded...All foods should be covered, validate accuracy of dates when labeled, and dated..." food is to be used as follows: 3.1-21(i)(2)5 times per week x 1 month, then 3.1-21(i)(3)3 times per week 2 months 1 time per week x 16 weeks The Director of Nursing/Designee will present the results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly

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Quality Assurance Committee

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/20/2025 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OME	3 NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728		IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/31/2025	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
				meeting monthly for 6 months then quarterly thereafter once compliance has been achieve a total of 6 months of monitori Re-education, frequency and/duration of reviews will be increased as needed, if areas noncompliance are identified through the auditing process, patterns that are identified will have an Action Plan initiated. QAPI committee will determine when 100% compliance is achieved or if ongoing monitor is required.	full d for ng. or of Any The	
F 0880 SS=D Bldg. 00	review, the facility control guidelines r for 1 of 2 residents (Resident 19) Findings include: 1a. During an obser P.M., Resident 19 v urinary catheter bag		F 0880	F880 Infection prevention an control 1. Allegedly the facility placed of F/C of resident #19 on the floor and failed to don a gown while caring for resident #19. DON/designee provided educate to QMA#7, C.N.A.'s #9 & #10 enhanced barrier requirement F/C so it cannot come in contawith the floor.	the or e ation on s and	02/21/2025

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the floor.

Event ID:

During an observation 01/30/25 at 10:17 A.M., half of the resident's urinary catheter bag was lying on

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2. Residents that have F/C or are

on enhanced barrier precautions

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED	
155728		B. WING		01/31/2025	
			<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD	
	IDDIC OR BOTT BILL	-		BUCKEYE ST	
MANDEF	RLEY HEALTH CAR	RE CENTER	OSG	OOD, IN 47037	
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	ID	1	(V5)
				PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG		DATE
				could be affected by this alleg	ed
		and observation on 01/30/25		practice. The Director of	
		lified Medication Aide (QMA)		Nursing/designee/Administrate	or
	7 indicated the resid	dent's urinary catheter bags		completed an audit of all resid	lents
	should be below bla	ndder level and should not		with F/C and all residents with	1
	touch the floor. She	went to Resident 19's room,		enhanced barrier precautions.	
	donned gloves and	removed the urinary catheter		DON/designee provided educ	
		d secured it to the side of the		to all nursing staff on enhance	
	bed.			barrier requirements and F/C	
				cannot come in contact with the	
	The clinical record	for the resident was reviewed		floor.	
		5 A.M. A Quarterly Minimum		noor.	
		sessment, dated 12/20/24,			
	` ′				
		nt was moderately cognitively			
	_	ent's diagnoses included, but		3. Director of	
		neurogenic bladder and		Nursing/Designee/Administrat	
		y. The resident had a urinary		completed an in-service with t	he
	catheter and was de	pendent on staff for all care.		facility staff regarding F/C	
				placement and Enhanced Bar	rier
	The clinical record	indicated the resident was on		Precautions requirements.	
	enhanced barrier pro	ecautions due to having a			
	urinary catheter.				
	The current facility	policy titled "Catheter Care,		4. Director of	
	-	vised date of September 2014,		Nursing/Designee/Administrat	or
	-	e Director of Nursing (DON)		will audit residents that have a	
		2 A.M. The policy indicated,		and Enhanced Barriers	,5
		lBe sure the catheter tubing			
		e kept off the floor"		precautions to ensure best	
	and dramage bag ar	е кері он ше пооғ		practices are being followed a	5
	11 7 1 1 1 1 1 1 1 1 1 1 1 1 1			follows: audit 5 per week x 4	h
	_	rvation on 01/31/25 at 1:01		weeks, 3 per day x 4 weeks, t	nen
	· ·	se Aide (CNA) 9 entered		1per week x 16 weeks. Any	
		and donned a gown and		identified concerns will be	
	-	forming urinary catheter care		immediately addressed. This	
	on the resident when	n CNA 10 walked into the		continue for no less than 6 mo	onths
		loves. CNA 10 went to the		and compliance is met.	
	right side of the resi	ident's bed, held the dirty			
		A 9 and placed them in a bag.			
		theter care was completed			
1		r		•	

CNA 10 rolled the resident to his left side to check

The Director of Nursing/Designee

CENTERSTOR	MEDICARE & MEDIC	AID SERVICES				OW	ID NO. 0936-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPI	LETED			
155728		B. W	ING		01/31	/2025			
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD				
					BUCKEYE ST				
MANDER	RLEY HEALTH CAR	RE CENTER		OSGO	DD, IN 47037				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
IAG		d him on his back. She	+	IAG			DATE		
					will present the results of thes	е			
	_	nd as she was getting ready to			reviews will be immediately				
	_	resident, the pillow touched			reported if concerns exist and	WIII			
	_	care was completed CNA 9			be discussed at the monthly				
		ware that CNA 10 did not don			Quality Assurance Committee				
		ntered the room to help care			meeting monthly for 6 months				
	for the resident.				then quarterly thereafter once				
					compliance has been achieved for				
	_	on 01/31/25 at 1:07 P.M., CNA			a total of 6 months of monitori	ng.			
	9 indicated when C	NA 10 entered the room to help			Re-education, frequency and/	or			
	with urinary cathete	er care she should have			duration of reviews will be				
	donned a gown.				increased as needed, if areas	of			
					noncompliance are identified				
	The current facility	policy titled, "Enhanced			through the auditing process.	Any			
	Barrier Precautions	" updated April 2024 was			patterns that are identified will	•			
		ministrator on 01/31/25 at 1:23			have an Action Plan initiated.				
	-	licated, "Enhanced barrier			QAPI committee will determine				
		are utilized to prevent the			when 100% compliance is	_			
		g resistant organisms			achieved or if ongoing monitor	rina			
		ntsEBPs employ targeted			is required.	mig			
		e during high contact resident			is required.				
	-	contact precautions do not							
		loves and gown are applied							
		the high contact resident care							
	_	es of high-contact resident care							
		the use of gown and gloves for							
	•	viding hygienechanging							
	_	vith toiletingdevice care or							
	•	erEBPs are indicated [when							
		for not otherwise apply] for							
		nds and/or indwelling medical							
	devices regardless of	of MDRO colonization"							
	3.1-18(b)								
	3.1-41(a)(2)						1		

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