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	01/31/2025

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. Survey dates: January 27, 28, 29, 30, and 31, 2025. Facility number: 000493 Provider number: 155728 AIM number: 100291300 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 6 Medicaid: 40 Other: 1 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 5, 2025.	F 0000	The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Manderley Healthcare. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk review for the alleged deficiencies within this plan of correction. Monica Ogden HFA	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review, and interview, the facility failed to treat a resident in a dignified manner during a meal service for 1 of 2 dining observations. (Resident 15)	F 0550	**F550 Resident Rights/Exercise of Rights/Meal service** 1.Allegedly the facility failed to treat resident #15 in a dignified	02/21/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monica Ogden	LHFA	02/17/2025

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	Findings include: Meal service was observed in the Main Dining Room on 01/27/25 at 12:01 P.M. At 12:10 P.M., Certified Nurse Aide (CNA) 6 stood upright next to Resident 15's wheelchair, to the resident's left 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. Several empty chairs were observed in the dining room. Another staff member was sitting down in a chair, at the same table, assisting another resident with their meal. CNA 6 continued to stand over Resident 15 while she assisted the resident with her meal until 12:36 P.M. The clinical record for Resident 15 was reviewed on 01/28/25 at 1:29 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, hypertension, dementia, anxiety, depression, and psychotic disorder. The resident was dependent on staff for assistance with eating. During an interview on 01/30/25 at 10:05 A.M., CNA 4 indicated when assisting a resident with 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		manner during meals service. DON/designee to provide education to nursing staff on the requirement on sit down on the requirement of assistance during meals. 2. Current residents that need assistance while eating could be affected by this alleged practice. The Director of Nursing/designee/Administrator completed an audit of all residents needing assistance while eating to ensure proper seating for staff. DON/designee to provide education to nursing staff on the requirement on sit down on the requirement of assistance during meals. 3. Director of Nursing/Designee/Administrator completed an in-service with the facility staff regarding Resident 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	

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	dignity..." 3.1-3(a)		will audit current residents that need assistance with eating to ensure staff are sitting while assisting in eating as follows: Residents needing assistance 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 concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. 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 Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/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 when 100% compliance is achieved or if ongoing monitoring is required.	

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F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on observation, record review, and interview, the facility failed to maintain resident records in a private manner related to information visible on a computer screen and on top of a medication cart for 2 of 6 random observations. (100 and 300 Hall Medication Carts) Findings include: 1. During a continuous observation on 01/27/25 from 2:17 P.M. to 2:39 P.M., the 100 Hall Medication Cart was left unattended. Resident 249's information was visible on the screen, - On 01/27/25 at 2:17 P.M., two Certified Nurse Aides (CNA) walked by the medication cart. - On 01/27/25 at 2:23 P.M., The computer screen on the medication cart remained unattended. - On 01/27/25 at 2:25 P.M., two CNAs walked by the medication cart. - On 01/27/25 at 2:28 P.M., a CNA walked by the medication cart. - On 01/27/25 at 2:31 P.M., RN 3 walked to the medication cart, made some notes on a piece of paper, and walked back to the nurse's station without closing the computer screen. - On 01/27/25 at 2:33 P.M., a Laundry Aide walked by the medication cart. - On 01/27/25 at 2:38 P.M., two CNAs and a Laundry Aide walked by the medication cart.	F 0583	**F583 Personal Privacy/Confidentiality of Records Open Screen** 1Hall 100 & 300 medication cart screen was allegedly left unattended along with a report sheet laying on top of this cart, and an empty medication card on top of the cart for residents 27 & 249 by the deficient practice. Employee #3 and #8 was educated during the survey process. 2 Current residents, if the medication cart was left unattended with screen open, empty med card and along with a report sheet, have the potential to be affected by the alleged deficient practice. The Director of Nursing /Designee completed an audit of all medication carts for compliance on proper policy of privacy & confidentiality of resident's records including computer screens. DON/Designee will provide education to nursing staff who pass medication on the requirement to protect resident data when passing medication.	02/21/2025

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	During an observation and interview on 01/27/25 at 2:39 P.M., RN (3) approached the medication cart and indicated the Qualified Medication Aide was passing medications that shift. The computer screen should have been locked when left unattended. During the observation there were mobile residents in the general area three to five feet of the medication cart. 2. During a continuous observation on 01/29/25 from 10:37 A.M. to 10:45 A.M., the medication cart for the 300 Hall was left unattended. A CNA Report Sheet was laying on the top of the cart and had several resident names listed with resident care information next to each name. A stack of empty medication cards were on top of the cart with one for Resident 27 lying on the top of the stack. No staff were standing in the immediate area of the cart. Several staff members and an independently mobile resident using a walker walked next to the cart during the observation time period. - On 01/29/25 at 10:39 A.M., two staff members walked past the medication cart, - On 01/29/25 at 10:39 A.M., a staff member walked past the medication cart carrying clean linens, - On 01/29/25 at 10:40 A.M., a staff member walked past the medication cart, - On 01/29/25 at 10:40 A.M., a QMA walked past the medication cart, - On 01/29/25 at 10:41 A.M., a staff member walked past the medication cart, - On 01/29/25 at 10:41 A.M., another staff member		3 The Director of Nursing/Designee/Administrator held an in-service with all licensed nursing staff and QMA's related to policy of confidentiality of information and personal privacy. 4 The Director of Nursing/Designee will audit medication carts to ensure the screens are closed and confidential records are left unattended as follows: 5 carts per week x 4 weeks, 3 carts per week x 4 weeks, 1 cart per week x 16 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. 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 Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. Any	

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	walked past the medication cart, - On 01/29/25 at 10:42 A.M., Resident 9, who was independently mobile with their walker, walked past the medication cart, and - On 01/29/25 at 10:45 A.M., a QMA walked up to the cart and began tearing off the portion of the medication cards containing the residents' names. During an interview on 01/29/25 at 11:18 A.M., QMA 8 indicated nothing should be left on top of the medication carts with resident names visible. The current "Confidentiality of Information and Personal Privacy" policy, with a revised date of 10/2017, was provided by the Director of Nursing (DON) on 01/30/25 at 10:25 A.M. The policy indicated, "...Our facility will protect and safeguard resident confidentiality and personal privacy...of all resident personal and medical records...The facility will strive to protect the resident's privacy regarding his or her...medical treatment...personal care...Access to resident personal and medical records will be limited to authorized staff and business associates..." 3.1-3(o)		patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review and interview, the facility failed to follow the physician's orders related to hold parameters for medications for 2 of 15 residents reviewed for Quality of Care. (Residents 15 and 24) Findings include:	F 0684	F 684 Quality of Care 1 Resident #15 & 24 was allegedly affected by the deficient practice. Resident #15 heart rate & #24 blood pressure parameters reviewed by facility Nurse	02/21/2025

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	1. The clinical record for Resident 15 was reviewed on 01/28/25 at 1:29 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/15/25, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, coronary artery disease, diabetes, and hypertension. A current open-ended physician's order, with a start date of 09/05/24, indicated the resident was to take Coreg (a cardiac medication) 25 milligrams (mg), two times a day related to hypertensive heart disease. The medication was to be held (not given) for a Heart Rate (HR) of less than or equal to 60 beats per minute and/or a blood pressure less than or equal to 110/50. The current October 2024, December 2024, and January 2025, Electronic Medication Administration Record (EMAR) for the resident's Coreg was provided by the Director of Nursing (DON) on 01/30/25 at 1:29 PM., and indicated the resident had received the Coreg medication when the resident's HR was less than or equal to 60 for the following dates and times: - 10/02/24 at bedtime the HR was 57, - 10/03/24 at 7:00 A.M. the HR was 60, - 10/04/24 at bedtime the HR was 60, - 10/06/24 at 7:00 A.M., the HR was 60, - 10/07/24 at 7:00 A.M., the HR was 60, - 10/09/24 at 7:00 A.M., the HR was 60, - 10/09/24 at bedtime the HR was 60, - 10/11/24 at bedtime the HR was 60, - 10/12/24 at bedtime the HR was 56, - 10/13/24 at 7:00 A.M., the HR was 60, - 10/13/24 at bedtime the HR was 54, - 10/15/24 at 7:00 A.M., the HR was 60, - 10/15/24 at bedtime the HR was 59, - 10/16/24 at 7:00 A.M., the HR was 60,		Practitioner and new order received to d/c parameters. 2 Current residents receiving blood pressure and heart rate medications and having parameters for administration have the potential to be affected by the alleged deficient practice and any identified concerns were immediately addressed and new orders followed as provided by the facility Nurse Practitioner. A 100% audit of current residents receiving blood pressure and heart rate medications and having parameter for administration has been completed by the Director of Nursing and reviewed with the facility Nurse Practitioner. Any identified concerns were immediately addressed and new orders followed as provided by the facility Nurse Practitioner. 3 The Administrator and Director of Nursing held an in-service with licensed nurses regarding “Administering Medication” as it relates to following hold parameters for blood pressure medications. 4 The Director of Nursing/Designee will audit resident’s receiving heart rate and blood pressure medications with parameters to ensure parameters	

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	- 10/21/24 at 7:00 A.M., the HR was 60, - 10/24/24 at 7:00 A.M., the HR was 60, - 10/24/24 at bedtime the HR was 59, - 10/25/24 at 7:00 A.M., the HR was 55, - 10/29/24 at bedtime the HR was 47, - 10/30/24 at 7:00 A.M., the HR was 60, - 12/04/24 at bedtime the HR was 59, - 12/05/24 at bedtime the HR was 59, - 12/06/24 at 7:00 A.M. the HR was 60, - 12/06/24 at bedtime the HR was 60, - 12/10/24 at 7:00 A.M., the HR was 60, - 12/11/24 at 7:00 A.M., the HR was 60, - 12/13/24 at 7:00 A.M., the HR was 60, - 12/14/24 at 7:00 A.M., the HR was 60, - 12/14/24 at bedtime the HR was 58, - 12/16/24 at bedtime the HR was 58, - 12/17/24 at bedtime the HR was 56, - 12/20/24 at bedtime the HR was 60, - 12/21/24 at bedtime the HR was 60, - 12/22/24 at 7:00 A.M., the HR was 60, - 12/24/24 at bedtime the HR was 60, - 12/25/24 at 7:00 A.M., the HR was 60, - 12/26/24 at 7:00 A.M., the HR was 60, - 12/27/24 at bedtime the HR was 60, - 12/28/24 at 7:00 A.M., the HR was 60, - 12/31/24 at 7:00 A.M., the HR was 60, - 01/01/25 at 7:00 A.M., the HR was 60, - 01/04/25 at 7:00 A.M., the HR was 60, - 01/06/25 at bedtime the HR was 60, - 01/07/25 at 7:00 A.M., the HR was 60, - 01/08/25 at 7:00 A.M., the HR was 60, - 01/14/25 at 7:00 A.M., the HR was 60, - 01/14/25 at bedtime the HR was 60, - 01/15/25 at 7:00 A.M., the HR was 60, - 01/15/25 at bedtime the HR was 60, - 01/17/25 at 7:00 A.M., the HR was 60, - 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		are being followed. The audit will be completed as follows: 5 residents with parameters x 4 weeks, then 3 residents with parameters x 4 weeks, then 1 resident with parameters x 16 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. 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 Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/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 when 100% compliance is achieved or if ongoing monitoring is required.	

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	- 01/27/25 at 7:00 A.M., the HR was 60. The Consultant Pharmacist's Medication Regime Review records for October and December 2024, were provided by the DON on 01/30/25 at 1:45 P.M., and indicated the following: - On 10/16/24, the pharmacist indicated there were times when the Coreg medication should have been held due to the resident's HR. This was not documented as such on the Medication Administration Record (MAR). Please educate the staff, and - On 12/18/24, the pharmacist indicated there were times when the Coreg medication should have been held due to the resident's HR. This was not documented as such and to please educate the staff. During an interview on 01/30/25 at 10:40 AM., the DON indicated she received the pharmacy recommendations when they came in. Once they came in, she would give the Nurse Practitioner (NP) the recommendations designated for the NP/MD. For the ones designated for nursing, she would address them. Pharmacy recommendations usually came in around the middle of the month. She tried to have them addressed within 30 days. The Care Plan for the resident being at risk for a cardiac event related to hypertension and coronary artery disease was provided by the DON on 01/30/25 at 1:45 P.M. The interventions included, but were not limited to, monitor vital signs as ordered. 2. The clinical record for Resident 24 was reviewed on 01/28/25 at 10:05 A.M. A Quarterly MDS assessment, dated 12/10/24, indicated the resident was cognitively intact. The resident's diagnoses			

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	included, but were not limited to, hip and knee replacement, hypertension, anxiety, depression, and chronic pain syndrome. A physician's order, dated 09/06/24 through 01/23/25, indicated the resident was to take Midodrine 10 mg, three times a day for low blood pressure. The staff were to hold the medication when the resident's systolic blood pressure (top) number was greater than 110 or the diastolic blood pressure (bottom number) was greater than 70. A current open-ended physician's order, with a start date of 01/23/25, indicated the resident was to take Midodrine 10 mg, with meals for low blood pressure. The staff were to hold the medication when the resident's systolic blood pressure number was greater than 110 or the diastolic blood pressure was greater than 70. The current November and December 2024 and January 2025 EMAR indicated the resident had received the Midodrine when the resident's systolic blood pressure was greater than 110 or the diastolic was greater than 70 for the following dates and times: - 11/04/24 at bedtime when the blood pressure was 114/67, - 11/09/24 at bedtime when the blood pressure was 120/61, - 11/14/24 in the morning when the blood pressure was 112/64, - 11/15/24 at midday when the blood pressure was 112/65, - 11/18/24 in the morning when the blood pressure was 112/60, - 11/26/24 in the morning when the blood pressure was 114/70, - 11/27/24 in the morning when the blood pressure			

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	was 114/60, - 12/16/24 in the morning when the blood pressure was 114/68, - 12/20/24 at bedtime when the blood pressure was 115/80, - 12/25/24 at midday when the blood pressure was 115/78 and at bedtime when the blood pressure was 110/82, - 01/01/25 at bedtime when the blood pressure was 127/88, - 01/04/25 in the morning when the blood pressure was 112/75, - 01/05/25 at bedtime when the blood pressure was 116/75, - 01/08/25 in the morning when the blood pressure was 102/72, - 01/10/25 at bedtime when the blood pressure was 123/79, - 01/13/25 in the morning when the blood pressure was 110/72 and at bedtime when the blood pressure was 115/67, - 01/15/25 at bedtime when the blood pressure was 115/69, - 01/17/25 at bedtime when the blood pressure was 111/74, and - 01/22/25 at bedtime when the blood pressure was 119/80. During an interview on 1/30/25 at 10:12 A.M., RN 2 indicated if a medication had hold parameters, then she would obtain the resident's vital signs and if the vitals were within the acceptable parameters, then she would give the medication. If the vitals were not within the parameters, she would not administer the medications and document why the medication was not administered. The current facility policy titled, "Administrating Medications", with a revised date of December			

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	2012, was provided by the DON on 01/30/25 at 1:29 P.M. The policy indicated, "...Medications shall be administered in a safe and timely manner, and as prescribed...The following information must be checked/verified for each resident prior to administering medications:...Vital signs, if necessary..." 3.1-37(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on record review and interview, the facility failed to treat a Urinary Tract Infection (UTI) in a timely manner for 1 of 2 residents reviewed for UTIs. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 01/28/25 at 2:10 P.M. An Admission Minimum Data Set assessment, dated 11/07/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, aortic valve disorder, urinary retention, and hypertension. A Nursing Note, dated 11/02/24 (Saturday) at 11:51 P.M., indicated new physician's orders were received to obtain a Urinalysis and Culture and Sensitivity (UA/CS). A Nursing Note, dated 11/03/24 (Sunday) at 8:38 A.M., indicated the resident denied pain or discomfort but experienced frequent incontinent episodes and frequent feelings of needing to void. The resident's urine had a strong odor.	F 0690	F690 B&B Inc, 1 Resident #1 was allegedly affected by the deficient practice Resident #1 U/A was ordered, obtained and results of U/A and failed to treat a UTI in a timely manner. 2 Current residents with orders for U/A have the potential to be affected by the alleged deficient practice. The physician will be notified if any U/A are not completed if identified. The Director of Nursing/Designee completed a 30 day look back of current residents with U/A orders to ensure completion as ordered. Any identified concerns were immediately addressed. 3 The Administrator/Director of Nursing held an in-service with the	02/21/2025

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	The laboratory (lab) report for the urinalysis indicated the resident's urine was collected on 11/06/24 (Wednesday) and the results were reported on 11/08/24 (Friday). The report indicated the following bacteria were detected in the sample: - Klebsiella pneumoniae, with an estimated high microbial load, - Citrobacter freundii/braak/koseri, with an estimated moderate microbial load, - Proteus mirabilis, with an estimated moderate microbial load, - Pseudomonas aeruginosa, with an estimated moderate microbial load, - Actinobaculum schaalii, with an estimated low microbial load, - Enterobacteriaceae, with an estimated low microbial load, and - Enterococcus faecalis, with an estimated low microbial load. The report recommended potential antibiotics to treat the bacteria. A Nursing Note, dated 11/11/24 (Monday) at 3:31 P.M., indicated a new physician's order was received to administer Fosfomycin (an antibiotic), 3 milligrams every 72 hours for three doses. A Nursing Note, dated 11/11/24 at 4:10 P.M., indicated the facility requested the pharmacy to STAT (immediate) send the Fosfomycin packet. A Shift Level Administration Note, dated 11/11/24 at 7:04 P.M., indicated the resident received first dose of the antibiotic to treat her UTI. During an interview on 01/31/25 at 11:12 A.M., the		licensed nurses regarding "Physician Services" related to U/A and treating in timely manner. 4 The Director of Nursing/Designee will review U/A orders received for current residents, the physician/NP note, and order entered for accuracy as follows: 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 16 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. 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 Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/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 when 100% compliance is achieved or if ongoing monitoring	

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	Director of Nursing (DON) indicated If UA/CS results were available on a Friday, the facility could contact the physician and the pharmacy and get an antibiotic started on the weekend. The current "Physician Orders" policy, with a revised date of 03/17/22, was provided by the DON on 01/30/25 at 10:25 A.M. The policy indicated, "...The facility is obligated to follow and carry out the orders of the prescriber in accordance with all applicable state and federal guidelines..." 3.1-41(a)(2) 3.1-49(a)		is required.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to store medications appropriately for 1 of 2 medication carts reviewed. (100-Hall Medication Cart) Findings include: During a continuous observation on 01/27/25 from 2:17 P.M. to 2:39 P.M., the 100-Hall Medication Cart was unlocked and left unattended, - On 01/27/25 at 2:17 P.M., two Certified Nurse Aides (CNA) walked by the medication cart, - On 01/27/25 at 2:23 P.M., The medication cart remained unlocked and unattended, - On 01/27/25 at 2:25 P.M., two CNAs walked by the medication cart, - On 01/27/25 at 2:28 P.M., a CNA walked by the	F 0761	**F761 Label/Store Drugs & Biologicals** 1Hall 100 medication cart was allegedly left unlocked and unattended by the deficient practice. DON/designee provided education to nursing staff on the requirement to secure medication and treatments by locking medication storage areas. 2 Current residents, if the medication cart was left unlocked, have the potential to be affected by the alleged deficient practice. The Director of Nursing /Designee completed an audit of	02/21/2025

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	medication cart, - On 01/27/25 at 2:31 P.M., RN 3 walked to the medication cart, made some notes on a piece of paper, and walked back to the nurse's station without locking the medication cart, - On 01/27/25 at 2:33 P.M., a Laundry Aide walked by the medication cart, and - On 01/27/25 at 2:38 P.M., two CNAs and a Laundry Aide walked by the medication cart. During an observation and interview on 01/27/25 at 2:39 P.M., RN 3 approached the medication cart and indicated the Qualified Medication Aide (QMA) had been passing medications this shift. The medication cart should be locked when left unattended. 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)		all medication carts for compliance on proper policy of labeling and storage of medications. DON/designee provided education to nursing staff on the requirement to secure medication and treatments by locking medication storage areas. 3 The Director of Nursing/Designee/Administrator held an in-service with all licensed nursing staff and QMA's related to policy of labeling and storage of medications. 4 The Director of Nursing/Designee will audit medication carts on proper policy of labeling and storage of medication to ensure carts are locked as follows: 5 carts per week x 4 weeks, 3 carts per week x 4 weeks, 1 cart per week x 16 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. 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 meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/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 when 100% compliance is achieved or if ongoing monitoring is required.	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on interview and record review, the facility failed to obtain a blood test and a urinalysis for 1 of 5 residents reviewed for laboratory services. (Resident 1) Findings include: 1a. The clinical record for Resident 1 was reviewed on 01/28/25 at 2:10 P.M. An Admission Minimum Data Set assessment, dated 11/07/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, Parkinson's disease, dementia, and aortic valve disorder. The resident's November 2024 physician's orders included, but were not limited to, the following:	F 0770	F770 Laboratory Services 1 Resident #1 was allegedly affected by the deficient practice. Resident #1 validated to have a lab requisition in place per MD order for Thursday lab draws. 2 Residents with lab orders have the potential to be affected by the alleged deficient practice. The Director of Nursing /Designee completed audit of the last 60 days to ensure ordered labs were completed for current	02/21/2025

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	- An order, with a start date of 11/02/24, to administer warfarin (an anticoagulant) medication. The resident was to receive 3.5 milligrams (mg), every Monday, Wednesday, Thursday, Saturday, and Sunday and 4 mg every Tuesday and Friday, and - An order, with a start date of 11/07/24, to obtain a weekly PT/INR (a blood test that measured how long it took for a blood sample to clot). 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. A Nursing Note, dated 11/11/24 at 2:56 P.M., indicated the lab was unable to collect the PT/INR sample on 11/07/24, 11/08/24, or 11/09/24. The facility spoke with the lab, and they were going to come and collect a STAT (immediate) PT/INR. The lab report for the PT/INR blood test indicated the sample was collected on 11/21/24 and resulted on 11/22/24. The results were within the recommended therapeutic range for the resident. A Nursing Note, dated 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 current dose of warfarin. During an interview on 01/31/25 at 11:12 A.M., the Director of Nursing (DON) indicated the lab said they couldn't obtain a sample from the resident so there was an order for a STAT PT/INR on 11/11/24. The sample was collected by the lab on 11/21/24 and resulted on 11/22/24. She would have liked to have had the lab drawn before 11/21/24.		residents. The physician will be notified of any missed lab orders if identified. 3 The Administrator/Director of Nursing held an in-service with all licensed nursing staff related to “Lab and Diagnostic Test Results-Clinical Protocol” related to obtaining ordered labs. 4 The Director of Nursing/Designee will audit current residents with lab orders for completion as ordered as follows: 5 residents per week x 4 weeks, 3 residents per week x 4 weeks, 1 resident per week x 16 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. 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 Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or	

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	1b. A Nursing Note, dated 11/02/24 (Saturday) at 11:51 P.M., indicated new physician's orders were received to obtain a Urinalysis and Culture and Sensitivity (UA/CS) for Resident 1. A Nursing Note, dated 11/03/24 (Sunday) at 8:38 A.M., indicated the resident denied pain or discomfort but experienced frequent incontinent episodes and frequent feelings of needing to void. The resident's urine had a strong odor. A Shift Level Administration Note, dated 11/04/24 (Monday) at 1:08 A.M., indicated the resident's urine sample was obtained and placed in the refrigerator. The laboratory (lab) report for the urinalysis indicated the resident's urine was collected on 11/06/24 (Wednesday) and the results were reported on 11/08/24 (Friday). The report indicated the following bacteria were detected in the sample: - Klebsiella pneumoniae, with an estimated high microbial load, - Citrobacter freundii/braak/koseri, with an estimated moderate microbial load, - Proteus mirabilis, with an estimated moderate microbial load, - Pseudomonas aeruginosa, with an estimated moderate microbial load, - Actinobaculum schaalii, with an estimated low microbial load, - Enterobacteriaceae, with an estimated low microbial load, and - Enterococcus faecalis, with an estimated low microbial load. The report recommended potential antibiotics to		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 when 100% compliance is achieved or if ongoing monitoring is required.	

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	treat the bacteria. A Nursing Note, dated 11/11/24 (Monday) at 3:31 P.M., indicated a new physician's order was received to administer Fosfomycin (an antibiotic), 3 milligrams every 72 hours for three doses. During an interview on 01/30/25 at 9:25 A.M., RN 2 indicated the lab would pick up specimens on Thursdays, Fridays, and Saturdays. If the facility had a urine specimen that needed to be sent out at any other time the facility would have to ship it. During an interview on 01/31/25 at 11:12 A.M., the DON indicated nursing staff were to collect the urine sample and contact the lab to pick up the sample. If the sample was collected on a day the lab didn't come to the facility, they would have to ship the sample out. She was unsure where the lab company was located. The current "Lab and Diagnostic Test Results - Clinical Protocol" with a revision date of September 2012, was provided by the DON on 01/29/25 at 2:54 P.M. The policy indicated, "...The physician will identify, and order diagnostic and lab testing based on diagnostic and monitoring needs...The staff will process test requisitions and arrange for tests..." 3.1-49(a)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to store foods in a sanitary manner related to unlabeled and outdated foods for 1 of 3 kitchen observations. This deficient practice had the	F 0812	**F812 Food Storage** 1Allegedly the facility failed to	02/21/2025

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	potential to affect 45 of 47 resident that receive food from the kitchen. Findings include: During the initial tour of the facility kitchen on 01/27/25 at 10:35 A.M., the following items were observed: - A 1/2 full half gallon of lactose free 2% milk that expired on 01/21/25, - An unopened half gallon of lactose free 2% milk 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. During an interview on 01/27/25 at 10:40 A.M., Cook 5 indicated the milk and brown gravy were expired and should have been thrown out. 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 policy indicated, "...Leftover food is used within 3 days or discarded...All foods should be covered, labeled, and dated..." 3.1-21(i)(2) 3.1-21(i)(3)		store food in a sanitary manner related to unlabeled and outdated foods which had the potential to affect 45 of 47 residents. ½ full half gallon of lactose free 2% milk, unopened half gallon of lactose free 2% milk and 1/3 pan full of gravy was outdated and discarded. 2 The lactose free 2% milk was replaced, and a complete audit was done to ensure no other food items were outdated. 3 Administrator/Dietary Manager completed an in-service with dietary staff regarding labeling of food and discarding of food after 3 days. 4 The Dietary Manager/designee will audit the stored food and validate accuracy of dates when food is to be used as follows: 5 times per week x 1 month, then 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 Quality Assurance Committee	

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			meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/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 when 100% compliance is achieved or if ongoing monitoring is required.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to urinary catheter care for 1 of 2 residents reviewed for infection control. (Resident 19) Findings include: 1a. During an observation on 01/27/25 at 1:50 P.M., Resident 19 was lying in bed. His entire urinary catheter bag was lying on the floor. The urine in the tubing appeared to be cloudy. During an observation 01/30/25 at 10:17 A.M., half of the resident's urinary catheter bag was lying on the floor.	F 0880	**F880 Infection prevention and control** 1.Allegedly the facility placed the F/C of resident #19 on the floor and failed to don a gown while caring for resident #19. DON/designee provided education to QMA#7, C.N.A.'s #9 & #10 on enhanced barrier requirements and F/C so it cannot come in contact with the floor. 2. Residents that have F/C or are on enhanced barrier precautions	02/21/2025

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	During an interview and observation on 01/30/25 at 10:18 A.M., Qualified Medication Aide (QMA) 7 indicated the resident's urinary catheter bags should be below bladder level and should not touch the floor. She went to Resident 19's room, donned gloves and removed the urinary catheter bag off the floor and secured it to the side of the bed. The clinical record for the resident was reviewed on 01/29/25 at 10:15 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/20/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, neurogenic bladder and obstructive uropathy. The resident had a urinary catheter and was dependent on staff for all care. The clinical record indicated the resident was on enhanced barrier precautions due to having a urinary catheter. The current facility policy titled "Catheter Care, Urinary", with a revised date of September 2014, was provided by the Director of Nursing (DON) on 01/30/25 at 11:12 A.M. The policy indicated, "...Infection Control...Be sure the catheter tubing and drainage bag are kept off the floor..." 1b. During an observation on 01/31/25 at 1:01 P.M., Certified Nurse Aide (CNA) 9 entered Resident 19's room and donned a gown and gloves. She was performing urinary catheter care on the resident when CNA 10 walked into the room and donned gloves. CNA 10 went to the right side of the resident's bed, held the dirty washcloths for CNA 9 and placed them in a bag. After the urinary catheter care was completed CNA 10 rolled the resident to his left side to check		could be affected by this alleged practice. The Director of Nursing/designee/Administrator completed an audit of all residents with F/C and all residents with enhanced barrier precautions. DON/designee provided education to all nursing staff on enhanced barrier requirements and F/C so it cannot come in contact with the floor. 3. Director of Nursing/Designee/Administrator completed an in-service with the facility staff regarding F/C placement and Enhanced Barrier Precautions requirements. 4. Director of Nursing/Designee/Administrator will audit residents that have a F/C and Enhanced Barriers precautions to ensure best practices are being followed as follows: audit 5 per week x 4 weeks, 3 per day x 4 weeks, then 1per week x 16 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 6 months and compliance is met. The Director of Nursing/Designee	

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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
	his backside and laid him on his back. She retrieved a pillow and as she was getting ready to place it behind the resident, the pillow touched her clothing. As the care was completed CNA 9 indicated she was aware that CNA 10 did not don a gown when she entered the room to help care for the resident. During an interview on 01/31/25 at 1:07 P.M., CNA 9 indicated when CNA 10 entered the room to help with urinary catheter care she should have donned a gown. The current facility policy titled, "Enhanced Barrier Precautions" updated April 2024 was provided by the Administrator on 01/31/25 at 1:23 P.M. The policy indicated, "...Enhanced barrier precautions [EBPs] are utilized to prevent the spread of multi-drug resistant organisms [MDROs] to residents...EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply...Gloves and gown are applied prior to performing the high contact resident care activities...Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include...providing hygiene...changing briefs or assisting with toileting...device care or use...urinary catheter...EBPs are indicated [when contact precautions for not otherwise apply] for residents with wounds and/or indwelling medical devices regardless of MDRO colonization..." 3.1-18(b) 3.1-41(a)(2)		will present the results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly Quality Assurance Committee meeting monthly for 6 months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/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 when 100% compliance is achieved or if ongoing monitoring is required.	