STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 00 B. WING	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: October 24, 25, 26, 27, 28, 31, November 1, and 2, 2016 Facility number: 000217 Provider number: 155324 AIM number: 100289590 Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 15 Medicaid: 35 Other: 9 Total: 59 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Q.R. completed by 14466 on November 04, 2016.	F 0000	This plan of correction is prepared and executed because of the provisions of State and federal law require it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character so as to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction. *Request paper compliance please	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 1 of 31 residents reviewed for accuracy of the MDS. (Resident #22) Findings include:	F 0278	F278 1. Residents affected by alleged deficient practice Resident #22, receiving hospice services, significant change MDS completed on 8/16/16 contained an item coding error which did not reflect a life expectancy of less than 6 months per the RAI manual coding definition	11/03/2016

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	On 10/31/16 at 10:55 a.m., Resident #22's clinical record was reviewed. Resident #22's Minimum Data Set (MDS) assessment, dated 8/15/16, indicated, ".... Health Conditions ... Prognosis ... Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? ... No ..." A review of Resident #22's November, 2016 Physician's Orders, indicated the resident was ordered to receive hospice (end of life care for terminally ill) services on 8/9/16. On 11/2/16 at 11:37 a.m., the MDS coordinator indicated she only codes the MDS, yes, if the resident has a physician's order indicating the resident is terminal (has less than 6 months to live). On 11/2/16 at 11:43 a.m., the MDS coordinator indicated she reviewed her RAI (Resident Assessment Instrument) manual and would update Resident #22's life expectancy question to reflect "yes." 3.1-31(d)		2. Residents at risk to be affected by alleged deficient practice Other residents receiving hospice services A 100% audit of MDS's completed on all other residents receiving hospice services was completed. Item coding errors in item J1400 were corrected immediately, MDS modifications were complete, transmitted, and accepted. 3. Systems to ensure alleged deficient practice does not recur MDS nurse reviewed RAI manual coding instructions for item J1400 RN MDS Coordinator will be educated on procedure to verify coding of item J1400 on residents receiving hospice care to verify item J1400 coding reflects life expectancy of 6 months or less. 4. Monitoring to ensure alleged deficient practice does not recur A daily list containing MDS's to be signed as complete by the RN MDS Coordinator will include instructions to verify correct coding of item J1400 on any resident receiving hospice services as coded correctly. MDS sign off lists will be retained in a binder ain the MDS Office. Ensure 100% PI compliance quarterly / PRN for 6 months	

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F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure staff repaired damaged walls for 5 resident rooms observed during environmental observations (Resident #10, Resident #13, Resident #21, Resident #31, and Resident #33), bathroom door and bathroom door jamb scuffs and gouges for 2 resident rooms (Resident #24 and Resident #50), and dresser damage in 1 resident room (Resident #3). Findings include: 1.) On 10/28/16 at 11:30 A.M., the wall beside the head of the bed of Resident #10 was observed to be scratched and gouged in multiple areas, revealing the underlying drywall. 2.) On 10/26/16 at 11:25 A.M., the wall behind the head of the bed of Resident #21 was observed to be scratched and gouged in multiple areas, revealing the underlying drywall. 3.) On 10/26/16 at 11:20 A.M., the wall behind the head of the bed of Resident	F 0465	F- 465 It is the policy of this facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. 1. Resident potentially affected by alleged deficient practice: ·Drywall damage and / or scuffed paint in the rooms of residents: 10, 13, 21, 31, 33, 24, and 50 has been repaired. ·The handles on the dresser in the room of resident 3 have been replaced. 2. Residents at risk to be affected by alleged deficient practice: · 100% of resident rooms in patient housing areas have been inspected and any damaged paint / drywall has been corrected. 3. Systems to ensure alleged deficient practice does not recur: ·Facility management will assess the condition of drywall / furnishings in each resident room	11/18/2016

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	#33 was observed to be scratched and gouged in multiple areas, revealing the underlying drywall. 4.) On 10/26/16 at 11:35 A.M., the corner of the wall by the room sink of Resident #31 was observed to be missing drywall finishing and corner support. On 10/28/16 at 11:35 A.M., Resident #31 indicated the corner of the wall by the room sink had been damaged for a lengthy time, and she had been told this would be repaired. The resident indicated she suspects staff forgot about this damage. 5.) On 10/26/16 at 11:40 A.M., the corner of the entry wall of Resident #13 was observed to be covered in rough, unfinished drywall mud. 6.) On 10/28/16 at 11:25 A.M., the bathroom door and door jambs of Resident #50 were observed to be scratched, scuffed, and gouged. 7.) On 10/28/16 at 10:40 A.M., the bathroom door and door jambs of Resident #24 were observed to be scratched, scuffed, and gouged. 8.) On 10/26/16 at 11:55 A.M., the dresser in the room of Resident #3 was		weekly as a part of our Grand Rounds process. Work orders will be generated at the time the damage is noted. 4. Monitoring to ensure alleged deficient practice does not recur: ·Executive Director will meet with Maintenance staff to review work orders and discuss the status of pending repairs. Meetings will be weekly for a period of 6 months. ·Maintenance Director or Designee will report on completion of generated work orders during monthly QI committee meeting for 4 consecutive months.	

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	observed to have broken metal handles from which protruded sharp broken ends. On 11/02/2016 at 10:40 AM, the Maintenance Supervisor indicated 5 individual room checks are conducted per week by the maintenance department. Direct care staff are to daily observe resident rooms for areas in need of repair and complete a maintenance work order relative to any damages. If a resident has personal furniture in need of repair, the unit nurse is responsible to notify maintenance as well as contact the family to ascertain whether or not the family wishes the furniture to be repaired. The Maintenance supervisor indicated the rooms in question do need repairs and will receive them. Regarding the broken dresser handles in the room of Resident #3, he did not deny this could be a safety issue and indicated the family will be contacted to obtain permission for repairs or removal of the dresser. On 11/2/16 at 11:30 A.M., the Director of Nursing provided a copy of the Resident Admission Agreement which indicated, "...services include comfortable environment..." 3.1-19(f)			

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