STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mitchell Manor	24 Teke Burton Dr Mitchell, IN 47446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to protect the residents right to be free from verbal abuse by a staff member for 1 of 3 residents reviewed for abuse. (Resident B, LPN 1)Findings include: During an interview on 12/17/25 at 11:40 a.m., Resident B indicated he had been at the facility for four months. He had a moped wreck and had broken his right leg. When asked if any staff had been verbally abusive to him, he indicated Let's just say she did not say anything I didn't say to her. On 12/17/25 at 11:45 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, multiple rib fractures, right tibia fracture, antisocial personality disorder, and seizures. A care plan, dated 8/2/25, indicated Resident B had potential to be verbally aggressive related to ineffective coping skills and antisocial personality disorder. The interventions were to analyze key times, places, circumstances, triggers, and what de-escalated behavior and document, assess resident's understanding of the situation, allow time for the resident to express self-feelings towards the situation, and when the resident becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation, if response was aggressive, staff to walk calmly away, and approach later. A progress note, dated 11/28/25 at 11:17 a.m., indicated on 11/27/25, Resident B was in the hallway yelling and cursing because of a reduction in his pain medications. He was demanding management staff be called-in to deal with this mess. He was educated the nurse practitioner discussed with him the reduction and was weaning him off his pain medication. He was calling staff a liar. Resident B was on one-on-one supervision with another nurse and was calming down. Another nurse from another hallway approached Resident B. Staff reported a verbal altercation when the second nurse approached Resident B telling him to calm down because he was upsetting other residents. Resident B escalated again and began cursing this nurse, and staff reported the nurse cursed at Resident B. Resident B indicated they both said things they should not. During an interview on 12/17/25 at 11:57 a.m., CNA 1 indicated on 11/27/25 at around 6:30 a.m., she was sitting at the nursing station when Resident B came up to the nursing station. He was screaming F*** you, God D*** it. Staff tried to redirect him and calm him down, but he was very upset. During an interview on 12/18/25 at 10:06 a.m., CNA 2 indicated on 11/27/25 around 7:00 a.m., she was sitting at the nursing station when Resident B came up. He was upset and mad because management was not at the facility. He started screaming and cussing. He had calmed down. Licensed Practical Nurse (LPN) 1 was not Resident B's nurse. LPN 1 went up to Resident B's face and told him to quit yelling. He indicated F*** You. LPN 1 indicated F*** You. Resident B indicated I would not F*** your nasty a**. LPN 1 indicated You couldn't get lucky enough. At 12/18/25 at 10:23 a.m., LPN 2 indicated on 11/27/25 around 6:30-6:45 a.m., she was Resident B's nurse. Resident B came up to the nursing station. He was screaming and cussing, pounding on the nursing station. He wanted his pain medication. LPN 2 was unsure why his pain medication order had changed. LPN 2 was on D hall checking his medication orders during the altercation. During an interview on 10:32 a.m., Qualified Medication Aide (QMA) 1 indicated on 11/27/25, she was at the nursing station. Resident B came up to nursing station screaming. He was screaming wanting the person in charge. Resident B started to calm down. LPN 1 came from A hall. She told Resident B he needed to stop screaming. He indicated F*** you. LPN 1 indicated F*** you. Resident B indicated I wouldn't F*** your nasty a**. On 12/17/25 at 2:15 p.m., the Administrator provided the facility policy, Abuse - Prevention dated 5/6/25 and indicated it was the policy currently being used by the facility. A review of the policy indicated, .It is the policy of this facility to prevent and prohibit all types of abuse, neglect .This deficient practice was corrected on 11/28/25 after the facility implemented a systemic plan of correction that included the following actions: all staff were in-serviced on abuse policies and procedures with ongoing monitoring. This citation relates to Intake 2682268. 3.1-27(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on record review and interview, the facility failed to protect the residents right to be free from misappropriation of resident property for 7 out of 7 residents reviewed. The residents had money withdrawn from their accounts and placed in multiple other resident accounts. (Resident D, Resident E, Resident F, Resident G, Resident H, Resident J, and Resident K)Findings include:On 12/17/25 at 10:40 a.m., a facility incident report, dated 10/6/25, was provided by the Administrator. A review of the report indicated an allegation of possible misappropriation of funds in the resident trust account by the Business Office Manager (BOM).The report indicated on 10/6/25, the Administrator discovered a potential discrepancy involving the resident trust account. She notified the Regional Field Controller to assist with the investigation. The BOM was suspended immediately pending an investigation. During the initial investigation by the facility, it was determined the allegation was substantiated by funds that could not be accounted for and there were unauthorized withdrawals made. The Regional Field Controllers and Divisional Controller continued with ongoing audits of the resident trust accounts. The report indicated the BOM was employed on 2/20/23 and the last day the BOM worked was on 10/3/25. On 10/9/25, the BOM was officially terminated by the facility. On 12/17/25 at 11:30 a.m., the Administrator provided an audit sheet for Resident Funds Management System (RFMS) issues and Care Cost issues, no date noted, the audit indicated resident accounts that had funds withdrawn and distributed to other resident accounts. The report indicated the following:-Batch 2357 ran on 1/3/24, indicated Resident D had $52.00 withdrawn and Resident K had $41.00 withdrawn. The funds, in the amount of $93.00, were placed in Resident Y's account.-Batch 2834 ran on 12/12/24, indicated Resident J had $136.00 withdrawn. The funds, in the amount of $136.00, were placed in Resident N's account.-Batch 2857 ran on 12/18/24, indicated Resident J had $136.00 withdrawn. The funds, in the amount of $136.00, were placed in Resident N's account.-Batch 2921 ran on 1/28/25, indicated Resident H had $136.00 withdrawn. The funds, in the amount of $136.00, were placed in Resident N's account.-Batch 2957 ran on 2/11/25, indicated Resident E had $390.00 withdrawn. The funds, in the amount of $390.00, were placed in Resident N's account.-Batch 3050 ran on 4/10/25, indicated Resident G had $105.00 withdrawn. The funds, in the amount of $105.00, were placed in Resident N's account.-Batch 3081 ran on 4/22/25, indicated Resident F had $149.00 withdrawn. The funds, in the amount of $149.00, were placed in Resident N's account.-Batch 3167 ran on 5/15/25, indicated Resident D had $722.85 withdrawn and Resident E had $410.86 withdrawn. The funds were as follows; Resident N - $180.00, Resident U - $3.00, Resident W - $120.00, and Resident X - $830.71, the amounts totaled $1133.71.-Batch 3232 ran on 6/12/25, indicated Resident E had $300.00 withdrawn. The funds were as follows; Resident N - $140.00 and Resident W - $160.00, the amounts totaled $300.00.-Batch 724256 ran on 8/18/25, indicated Resident D had $551.40 withdrawn. The funds were placed as follows; Resident N - $136.00, Resident - O $86.40, Resident S - $110. 00, Resident T - $24.00, Resident U - $155.00, and Resident V - $40.00, the amounts totaled $551.40.-Batch 724300 ran on 8/28/25, indicated Resident E had $799.00 withdrawn. The funds were as follows; Resident D - $83.67, Resident Q - $152.27, Resident R - $135.37, and Resident Z - $427.69, the amounts totaled $799. 00.-Batch 724346 ran on 9/22/25, indicated Resident D had $1485.00 withdrawn. The funds were placed as follows; Resident L - $826.45, Resident M - $4.00, Resident N - $409.00, Resident O - 86.70, Resident P - $158.85, the amounts totaled $1485.00.The audit sheet of the RFMS Petty Cash fund was reviewed and indicated 100 transactions of various residents from February 2023 through September 2025 that did not have a verification ticket or resident/resident representative signature that were completed by the BOM. During an interview with the Administrator on 12/17/25 at 1:50 p.m., she indicated the facility utilized a combined resident funds account that was managed by a system called RFMS (Resident Funds Management System), she indicated that each resident had their own accounts within that fund. The Administrator indicated the resident funds are kept separate from the facility fund account. The Administrator indicated, on 10/6/25, it was discovered that there was a potential discrepancy with money in the RFMS handled by the facility BOM. She indicated she notified the Regional Field Controller, and an investigation was started immediately. The Administrator indicated the BOM was suspended pending investigation. She indicated the discrepancy was verified within the accounts and an audit was started on all accounts in the resident trust fund, the BOM was terminated upon verification of the discrepancy. The Administrator indicated through the investigation it was discovered that the BOM would move money from one or more resident accounts to other resident accounts in varying amounts. The Administrator indicated it was verified

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a weight loss was monitored for 1 of 3 residents reviewed for nutrition. (Resident C)Findings include: On 12/17/25 at 2:25 p.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, Parkinson's disease, chronic kidney disease, muscle weakness, dysphagia (difficulty swallowing), and mood disorder. A care plan, dated 8/22/25, indicated Resident C had a nutritional problem or a potential nutritional problem. The interventions were to provide and serve diet as ordered and the registered dietician to evaluate and make diet change recommendations as needed. A Care Management Note, dated 8/8/25 at 10:31 a.m., indicated Resident C was a new admission and the admission weight was 158.3 pounds. A Dietary Note, dated 8/8/25 at 10:53 a.m., indicated Resident C's weight was 180 pounds. His ideal body weight was 150 pounds. He had no significant weight change in the last 30/180 days. A weight variance was anticipated due to swelling, fluid balance, medications, and diagnoses. Resident C had diagnosis of dementia and was at risk for appetite, intake, and/or weight changes as disease progressed. The nutritional interventions were to serve diet as ordered by physician, to honor food preference, and monitor weights. On 8/14/25 at 10:33 a.m., the Weights and Vitals Summary indicated Resident C weighed 178 pounds. A Care Management Note, dated 8/15/25 at 1:56 a.m., indicated Resident C's weight was 178 pounds. He was on a regular diet. The note lacked documentation of this weight being inaccurate or he had a 19.7 pound increase. The clinical record lacked documentation of weight or a care management note from 8/17/25 through 8/23/25. On 8/24/25 at 4:45 p.m., the Weights and Vitals Summary indicated Resident C weighed 165 pounds. A Care Management Note, dated 8/29/25 at 11:24 a.m., indicated Resident C's weight was 165 pounds on 8/24/25. He was on a regular diet. The note lacked documentation of weight of 178 being inaccurate. On 9/3/25 at 10:22 a.m., the Weights and Vitals Summary indicated Resident C weighed 166.9 pounds. A Care Management Note, dated 9/5/25 at 1:37 p.m., indicated Resident C's weight was 166.9 pounds on 9/3/25. He had an 11 pounds weight loss in 30 days compared to the weight of 178 pounds on 8/14/25. His weight had been stable for 3 weeks. He was on a regular diet. His weights continued to be monitored. The note lacked documentation the weight of 178 was inaccurate or of any weight loss interventions. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Dietary Note, dated 9/5/25 at 2:13 p.m., indicated Resident C weight was 166.9 pounds. Resident C had a significant weight loss of 11.1 pounds which was a 6.2 percent weight loss in 30 days. He was noted to be on a diuretic. His interventions were to continue to monitor weights. The clinical record lacked documentation of weight or a care management note dated 9/7/25 through 9/13/25. A Care Management note, dated 9/19/25 at 7:46 a.m., indicated Resident C remained on enhanced barrier precautions related to indwelling catheter. The note lacked documentation of monitoring for weight loss. On 9/22/25 at 6:56 a.m., Resident C was yelling in pain from his indwelling catheter. The Nurse Practitioner ordered pain medication and to send him to the hospital for evaluation. On 9/28/25 at 4:13 p.m., the Weights and Vitals Summary indicated Resident C weighed 105 pounds. A Dietary Note, dated 10/3/25 at 11:07 a.m., indicated Resident C was a readmission. His weight was 166 pounds (weight was used from the 9/3/25 related to possible weight error on readmission). His ideal body weight was 154 pounds. No documented significant weight loss in 30/180 days. The most recent weight from readmission was 105 pounds (weight loss of 60 pounds) was likely inaccurate. The hospital records indicated weight was 156 pounds. Resident C had diagnosis of dementia and was at risk for appetite, intake and/or weight changes as disease progresses. The interventions were to provide diet as order by physician and to monitor weight and labs. The note lacked documentation of any health shakes supplements being ordered twice a day. A Care Management Note, dated 10/3/25 at 1:46 p.m., indicated Resident C had an indwelling catheter in place because of urinary retention. The note lacked documentation of 9/28/25 weight of 105 pounds being inaccurate, an order for weekly weights or any new supplements orders. A Communication Note to the Physician, dated 10/9/25 at 12:00 a.m., indicated Resident C was in significant distress and was shouting for help and was holding his abdomen. The nurse practitioner indicated to send Resident C to the emergency room for evaluation and treatment. A readmission Dietary Note, dated 10/17/25 at 9:36 a.m., indicated Resident C's weight was 166 pounds. The weight was used from most recent hospital record because the previous facility weight of 105 pounds was likely an error. His ideal body weight was 154 pounds. No documented significant weight change in 30/180 days. The most recent weight from readmission of 105 pounds (weight loss of 60 pounds) was likely inaccurate. The hospital record indicated on admission to the hospital his weight was 156 pounds. He had a diagnosis of dementia and was at risk for appetite, intake, and/or weight changes as his disease progressed. The interventions were diet as ordered by physician and monitor weights. A Care Management Note, dated 10/20/25 at 11:06 a.m., indicated Resident C returned from the hospital with urinary catheter in place. The note lacked documentation of any monitoring of Resident C's weights since his return from the hospital on [DATE]. On 10/23/25 at 1:07 p.m., the Weights and Vitals Summary indicated Resident C weighed 103.6 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Management Note, dated 10/24/25 at 8:04 a.m., indicated Resident C's weight was 103.6 pounds on 10/23/25. This weight was triggering a 7.5% weight loss on compared to 8/14/25 which was 178 pounds. He had a recent hospital stay weight loss. The interdisciplinary team recommended to add med-pass (nutritional supplement) and fortified foods. The clinical record lacked documentation of weight or a care management note dated 10/26/25 through 11/1/25. A Dietary Note, dated 10/31/25 at 9:59 a.m., indicated Resident C's current weight was 103.6 pounds. He had a significant weight loss of 74.4 pounds which was 41.8% in 180 days. He was started on med-pass and mirtazapine (antidepressant for weight loss) 7.5 milligrams daily. He had dramatic weight fluctuations over the past 6 months and hospitalization. His weights were trending between 100 - 105 pounds. He was observed to be lying in bed and appeared in bed cachectic (condition causes significant weight loss and muscle loss) with global muscle and fat wasting. A care plan, dated 10/31/25, indicated Resident C had an unplanned/unexpected weight loss related to poor food intake and recent hospitalization. The interventions were to evaluate any weight loss; determine percentage lost and follow facility protocol for weight loss; give supplements as ordered; and to offer substitutes as requested. On 11/6/25 at 10:48 a.m., the Weights and Vitals Summary indicated Resident C weighed 104 pounds. A Care Management Note, dated 11/7/25 at 11:45 a.m., indicated Resident C required assistance to eat. His weight on 11/6/25 was 104 pounds which triggered a 10% weight loss in 180 days compared to 8/14/25 weight of 178 pounds. This was a loss of 74 pounds. His weight loss was attributed to recent illness and hospitalizations. His diet was regular with easy to chew texture and med pass three times a day. The interdisciplinary recommended weekly weights until stable. A Care Management Note, dated 11/14/25 at 8:18 a.m., indicated Resident C's weight, on 11/13/25, was 104 pounds which triggered a 10% weight loss in 180 days compared to 8/14/25 weight of 178 pounds. He had a recent hospitalization and returned with a readmission weight of 103.6 pounds. His weight was stable for 3 weeks. He received med pass 3 times a day. A Dietary Note, dated 11/14/25 at 1:48 p.m., indicated Resident C's current weight was 104 pounds. He had a significant weight loss of 74 pounds which was 41.6% in 180 days. He was on med-pass and mirtazapine 7. 5 milligrams daily. He had dramatic weight fluctuations over the past 6 months and hospitalization. His weights were stable between 100 - 105 pounds. On 11/19/25 at 4:08 p.m., the Weights and Vitals Summary indicated Resident C weighed 105.1 pounds. A Care Management Note, dated 11/21/25 at 11:33 a.m., indicated Resident C's weight, on 11/19/25, was 105 pounds. His weight was stable since 9/28/25. The comparison weight of 165 pounds which was a loss of 59.9 pounds. He was on a regular mechanically altered diet, med pass three times a day, and mirtazapine as an appetite stimulant. His weight loss was from acute illness and hospitalization. The clinical record lacked documentation of weekly weight or care management note dated 11/23/25 through 11/29/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The clinical record lacked documentation of weekly weight or care management note dated 11/30/25 through 12/6/25. On 12/1/25 at 1:41 a.m., the Weights and Vitals Summary indicated Resident C weighed 102 pounds. A Care Management Note, dated 12/12/25 at 1:45 p.m., indicated Resident C's weight was 102 pounds which triggered a 7.5% weight loss compared to the weight of 166.9 pounds on 9/3/25. This was a loss of 64. 9 pounds. His weight loss was attributed to acute illness and hospitalizations. His weight loss had been stable since 9/28/25. He was on pureed diet and nectar thickened liquids. He returned from the hospital on [DATE]. During an interview on 12/18/25 at 11:25 a.m., Licensed Practical Nurse (LPN) 3 indicated Resident C had been sick quite a bit. She was unsure if he had weight loss. During an interview on 12/18/25 at 11:30 a.m., CNA 3 indicated Resident C required assistance with eating meals. During an interview on 12/18/25 at 1:10 p.m., the Director of Nursing (DON) indicated a new admission was weighed on the day of admission or the day after and then weekly for 4 weeks. The IDT met weekly for four weeks after admission, and if stable would discharge from the IDT monitoring. On 12/18/25 at 2:20 p.m., the DON provided a physician's order which indicated health shakes twice a day for weight loss. The order was entered into the electronic health record on 12/18/25 but dated for 9/30/25. On 12/18/25 at 3:29 p.m., the DON provided the facility policy, Resident at Risk [RAR] Policy dated 5/6/25 and indicated it was the policy currently being used by the facility. A review of the policy indicated, .1. The facility establishes a consistent method of weighting residents, verifying weights upon admission, monitoring weights over time to identify weight loss/gain, verifying weights when changes occur, determining interventions, and reassessing interventions when appropriate .2. Residents newly admitted to the facility are weighed weekly for the first 4 weeks after admission to establish baseline and stability. This citation relates to Intake 2650504. 3.1-46(a)(1)