

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Mitchell Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to revise the care plan with new interventions after a fall for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/15/26 at 9:00 a.m. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, and reduced mobility. A quarterly Minimum Data Set (MDS) assessment, dated 6/5/26, indicated Resident B was not cognitively intact. A progress note, dated 6/20/26 at 7:11 p.m., indicated Resident B was attempting to go into another resident's room and her wheelchair wheel was stuck on the door frame. Resident B sat herself onto the floor on her bottom and attempted to scoot into the room. Resident B was assisted back up to her wheelchair. A progress note, dated 6/21/26 at 7:15 p.m., indicated Resident B lowered herself to the floor from her wheelchair. Resident B was assisted up to her wheelchair. A progress note, dated 7/6/26 at 6:15 p.m., indicated at approximately 4:55 p.m., observed Resident B move to the edge of her wheelchair. Resident B used the handrail to scoot up and lower herself to the floor. A care plan, dated 12/12/25, indicated the care plan had not been revised with new interventions for falls on 6/20/26, 6/21/26, and 7/6/26. During an interview on 7/15/26 at 11:37 a.m., CNA 1 indicated Resident B had a couple falls in the last couple months. Resident B's falls seemed to be from her pulling herself and slipping. The interventions the facility were using were to observe Resident B more often and more frequent position changes in the wheelchair. During an interview on 7/15/26 at 11:50 a.m., the Director of Nursing (DON) indicated Resident B's care plan should have been revised with the appropriate interventions. The interventions in place after her falls were more frequent observations and frequent position changes in her wheelchair. On 7/15/26 at 12:33 p.m., the Director of Nursing (DON) provided a copy of facility policy, titled Comprehensive Care Plans and Revisions, dated 8/29/25, and indicated this was the current policy used by the facility. A review of the policy indicated the facility should monitor the resident to identify changes in the resident's condition and when these changes occur the facility should review and update the plan of care to reflect the change in care delivery. This citation relates to Intakes 3075725 and 3092873.410 IAC (Indiana Administrative Code) 16.2-3.1-35(d)(2)(B)		

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