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	05/01/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe and sanitary environment for 1 of 4 hallways for 5 of 5 days during the survey. Strong urine odors were present. (Hallway B)Findings include: On 4/27/26 at 10:10 a.m., during the initial walkthrough of the facility a strong odor of urine was noted at the beginning of Hallway B. On 4/28/26 at 11:27 a.m., a strong urine odor was noted down Hallway B. On 4/29/26 at 8:47 a.m., a strong urine odor was noted down Hallway B. On 4/29/26 at 10:00 a.m., a strong urine odor was noted at entrance of Hallway B. There were multiple residents observed to be sitting in hall at this time. On 4/30/26 at 10:21 a.m., a strong urine odor was noted down Hallway B. On 5/1/26 at 12:15 p.m., a strong urine odor was noted down Hallway B.During an interview with CNA 1 on 4/30/26 at 1:50 p.m., she indicated there was a noticeable smell of urine down Hallway B. During an interview with CNA 2 on 5/1/26 at 12:20 p.m., she indicated there is a noticeable urine odor down Hallway B.During an interview with the DON (Director of Nursing) on 5/1/26 at 12:25 p.m., she indicated they were aware of a strong odor at the entrance of Hallway B. She indicated it is the policy of the facility that all residents have the right to a clean and comfortable environment.This citation relates to Intake 3000836.410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 2 of 24 reviewed for MDS accuracy. PASSAR screenings and antidepressant medications were coded inaccurately. (Resident 64, Resident 9) 1. On 4/30/26 at 11:15 a.m., Resident 64's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety and bipolar disorder. A Preadmission Screening and Resident Review (PASARR), dated 5/8/23, indicated Resident 64 had Level II screening. An annual MDS assessment, dated 1/30/26, indicated Resident B was not currently considered by the State to have a Level II PASARR screening. 2. Resident 9's clinical record was reviewed on 4/28/26 at 3:09 p.m., the diagnoses included, but were not limited to schizoaffective disorder (a mental health condition that includes symptoms of both schizophrenia and mood disorders), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized anxiety disorder (persistent, excessive, and uncontrollable worry about daily events, lasting at least six months). A physician's order, dated 6/26/25, indicated Trazodone HCl (an antidepressant medication used to treat major depressive disorder, anxiety disorders, and insomnia) Oral Tablet 50 mg (milligram), give 25 mg by mouth at bedtime for insomnia. The Quarterly MDS Assessment, dated 2/18/26, did not indicate the resident took an antidepressant medication on Item N0415. A review of the RAI, Version 3.0 User's Manual Version 1.20.1, October 2025, on 4/29/26 at 10:49 a.m., indicated .Item N0415, High-Risk Drug Classes: Use .Review the resident's medical record for documentation that any of these medications were received by the resident .during the 7-day lookback period .Code medications in Item N0415 according to the medication's therapeutic category and/or pharmacological classification, not how it is used. During an interview with the MDS Coordinator on 5/1/26 at 1:40 p.m., she indicated that the resident was taking an antidepressant at the time of the Quarterly MDS assessment, dated 2/18/26, and Item N0415C1 should have been coded yes. The MDS Coordinator indicated they do not have an MDS policy, they use the RAI tool to code MDS Assessments. 410 IAC (Indiana Administrative Code) 16.2-3.1-31(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a comprehensive plan of care was created for a resident who was a smoker, to ensure appropriate supervision and interventions were in place to prevent the potential for accidents for 1 of 4 residents reviewed for accidents. (Resident 55)Findings include: On 4/28/26 at 11:12 a.m., Resident 55 was observed to be smoking during the designated smoking time with staff supervision.On 4/29/26 at 11:00 a.m., Resident 55 was observed to be smoking during the designated smoking time with staff supervision.On 4/30/26 at 11:10 a.m., Resident 55 was observed to be smoking during the designated smoking time with staff supervision.A review of the resident smoking list, provided by the facility on 4/27/26 at 11:44 a.m., indicated that Resident 55 was a smoker.Resident 55's clinical record was reviewed on 4/30/26 at 9:46 a.m. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (a progressive, incurable lung disease, primarily caused by smoking, that restricts airflow, making it difficult to breathe), paranoid schizophrenia (a chronic mental health disorder characterized by intense, irrational paranoia, delusions, and auditory hallucinations), and mild neurocognitive disorder (a state of slight decline in cognitive abilities; memory, language, or thinking, that is noticeable to the individual or others but does not interfere with daily independence).Resident 55's clinical record lacked a care plan for smoking.The admission MDS (Minimum Data Set) assessment, dated 10/20/25, indicated the resident was a smoker.A review of Resident 55's progress notes on admission indicated the resident was a smoker and continued to be a smoker through present.During an interview on 5/1/26 at 9:00 a.m., the resident confirmed he was a current smoker and had smoked since he was admitted to the facility.During an interview on 5/1/26 at 11:20 a.m., the DON (Director of Nursing), indicated the resident was a smoker. She indicated they are to complete a smoking assessment on admission and then quarterly for each resident who smokes. The DON indicated the any resident who smokes should have a care plan implemented on admission.On 5/1/26 at 12:25 p.m., the DON indicated there was no care plan related to smoking for Resident 55. On 5/1/26 at 11:22 a.m., the DON provided a policy labeled Comprehensive Care Plans and Revisions, dated 8/29/25, and indicated this was a current policy used by the facility. The policy indicated, .A comprehensive care plan must be - (i) developed within 7 days after completion of the comprehensive assessment.(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.On 5/1/26 at 12:25 p.m., the DON provided a policy labeled Facility Safety, Smoking Facility, dated 4/1/26, and indicated this was a current policy used by the facility. The policy indicated, Procedure.7. All residents who smoke will have a smoking assessment completed with the appropriate care plan interventions documented.Resident Smoking Determination.3. Once a smoking assessment is completed, the Inter-disciplinary Team (IDT) will review the resident smoking assessments and develop an individualized smoking care plan that includes, but is not limited to, smoking safety/assistance and education of smoking policy and level of understanding. 4. The DON or designee will review resident smoking assessments and care plans for accuracy and appropriateness.410 IAC (Indiana Administrative Code) 16.2-3.1-35(a)