STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. Building B. Wing	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manderley Health Care Center	806 S Buckeye St Osgood, IN 47037

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review, and interview, the facility failed to follow physician's orders related to cardiac medication hold parameters, obtaining vital signs and weights, and notifying the physician of weight changes for 3 of 17 residents reviewed for Quality of Care. (Residents 3, 40 and 14)Findings include: 1.Resident 3's clinical record was reviewed on 01/21/2026 at 2:34 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/31/2025, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, dementia (decline in mental abilities), anxiety, depression, bipolar disorder (a chronic mental illness characterized by extreme mood swings), and orthostatic hypotension(sustained increase in blood pressure after standing). A Pharmacy Consultant Note To Attending Physician/Prescriber, dated 07/02/2025, indicated the resident had an order for Midodrine 2.5 milligrams (mg) three times a day. The resident's blood pressures were being recorded twice a day, and some Systolic Blood Pressures (SBP) (top number) were measuring 130 or higher. Please consider adding a hold parameter to this medication, so BP (Blood Pressure) must be assessed, recorded, and evaluated for medication administration. A Physician's order, with a start date of 07/03/2025 and end date of 07/17/2025, indicated the resident was to receive Midodrine 2.5 mg after each meal related to hypotension. The medication was to be held if the resident's SBP was greater than 115 or the DBP (bottom number) was greater than 65. The July 2025 Electronic Medication Administration Record (EMAR), indicated the resident had received the medication when their systolic blood pressure was greater than 115, or the diastolic blood pressure was greater than 65, or when the blood pressure was not obtained, on the following dates and times: - 07/08/2025 at 6:00 P.M., when the blood pressure was 124/69, - 07/10/2025 at 1:00 P.M., when the blood pressure was 142/87 and at 6:00 P.M., when the blood pressure was 144/78,- 07/11/2025 at 9:00 A.M., when the blood pressure was 114/66 and at 1:00 P.M., when the blood pressure was not obtained, - 07/12/2025 at 9:00 A.M., when the blood pressure was 113/69 and at 1:00 P.M., when the blood pressure was not obtained, - 07/14/2025 at 6:00 P.M., when the blood pressure was 129/80, - 07/15/2025 at 9:00 A.M., when the blood pressure was 114/80, at 1:00 P.M., when the blood pressure was 100/72, and at 6:00 P.M., when the blood pressure was 108/72, - 07/16/2025 at 9:00 A.M., when the blood pressure was 90/72, and at 1:00 P.M., when the blood pressure was 101/72, and - 07/17/2025 at 1:00 P.M., when the blood pressure was 107/68. During an interview, on 01/23/2026 at 10:40 A.M., RN 2 indicated the physician's orders should be followed regarding medication parameters. If there are blood pressure parameters, then the blood pressure should be obtained prior to each medication administration. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The clinical record for Resident 40 was reviewed on 01/21/2026 at 2:42 P.M. A Quarterly MDS assessment, dated 11/18/2025, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, diabetes, renal insufficiency, coronary artery disease, and seizure disorder. The resident's current physician's order included, but were not limited to, an open-ended physician's order, with a start date of 10/29/2025, that indicated staff were to obtain the resident's vital signs (blood pressure, heart rate, temperature, and respiratory rate) once a week in the evenings on Wednesdays. The resident's record lacked documentation of the resident's vital signs since the order was put in place on 10/29/2025. During an interview, on 01/23/2026 at 2:08 P.M., the Director of Nursing (DON) indicated the order was put in the computer on 10/29/2025, but no weekly vital sign assessments were documented. 3.The clinical record for Resident 14 was reviewed on 01/21/2026 at 2:14 P.M. A Quarterly MDS assessment, dated 10/20/2025, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, anemia, congestive heart failure, lower extremity edema, and dementia. The resident's EMAR indicated the resident had a physician's order to be weighed daily on day shift. Staff were to notify the MD if the resident had a weight gain of greater than three pounds in one day, or five pounds in one week. The order had a start date of 09/05/2025, and a discontinued date of 01/14/2026. The physician's phone number was listed on the order. The staff failed to notify the physician or obtain the resident's weight on the following days: -09/07/2025, the resident weighed 119.5 pounds,-09/08/2025, the resident weighed 125.6 pounds, a gain of 6.1 pounds,-09/12/2025, no weight was obtained,-09/18/2025, no weight was obtained,-10/20/2026, no weight was obtained,-10/26/2025, no weight was obtained,-10/27/2025, no weight was obtained,-11/04/2025, no weight was obtained,-11/06/2025, no weight was obtained,-12/07/2025, the resident weighed 117.5 pounds-12/08/2025, the resident weighed 120.8 pounds, a gain of 3.3 pounds,-01/01/2026, the resident weighed 121.4 pounds,-01/02/2026, the resident weighed 124.8 pounds, a gain of 3.4 pounds. The Progress Notes, dated from September 2025 to January 2026, lacked documentation the physician was notified of the resident's weight gains or why the resident's weights were not obtained. During an interview, on 01/28/2026 at 10:31 A.M., RN 2 indicated the resident had a fall at home and had surgery for a hip fracture. She had some swelling in her lower legs. Weights were documented on the computer. Normally, they would document in a progress note when the physician was notified. For residents on daily weights, if there was an increase, staff should notify the physician. The resident's weights would be documented either in the Vitals section of the resident's record or on the EMAR. During an interview, on 01/28/2026 at12:52 P.M., the DON indicated the facility did not have a policy that stated nurses were to follow physician's orders, it was just standard nursing practice. The current Change in a Resident's Condition or Status policy, with a revised date of February 2021, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was provided by the DON on 01/28/2026 at 12:51 P.M. The policy indicated.Our facility promptly notifies .attending physician .of changes in the resident's medical .condition .when there has been .specific instruction to notify the physician of changes in the resident's condition . 3.1-37(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner for 2 of 3 kitchen observations and unmarked random food containers in the resident snack refrigerator for 1 of 1 resident snack refrigerators observed. Findings include: During the initial kitchen tour with the Dietary Manager (DM), on 01/20/2026 at 10:33 A.M., the following was observed: -a large, enclosed meal tray cart had a tray on top with a toaster sitting on the tray. The tray was heavily littered with breadcrumbs. An unlabeled respiratory medication inhaler was sitting on top of the cart within an inch of a bottle of seasoning spices, -The walk-in freezer had two frozen bottles of water, one was a green two-liter bottle, one was a clear old juice bottle, both were stained brown. The DM indicated they regularly used the bottles to cool down the pitchers of prepared iced tea, -An open rack of dishes consisting of small bowls and plates was littered with crumbs, the DM indicated they were clean dishes, -One large trash can that sat at the end of a food prep table had no lid and was over half full of garbage. The DM indicated they were getting ready to take it out. The lid was trapped between the can and the food prep table. The lid had a six-to-eight-inch hole in the center with pieces of food stuck on the lid surrounding the hole. No staff were actively using the trash can or in the process of taking it out, -In the dry storage room,-One large blue tub with a lid, labeled Flour Filled 10/4/24, with a small amount of flour and a scoop inside the tub, and-An eight-inch hole in the floor covered with a towel that the DM indicated was a drain. There were two pipes with open ends that extended over the hole, The DM indicated the inhaler was the cook's and she had asthma. During an interview, on 01/28/2026 at 10:03 A.M., Dietary Aide (DA) 5, indicated the sugar bin had a place to put the scoop, she did not leave the scoop in the bin with the sugar. She generally just managed the dish washing. During a tour of the kitchen, on 01/28/2026 at 11:02 A.M., the following was observed: -A clear, brown-stained bottle of frozen water was in the walk-in freezer, and-One large blue tub with a lid, labeled Flour Filled 10/4/24, with a small amount of flour and a scoop inside the tub. During an interview, while still in the kitchen, scoops should not be left in the flour bin. They put the frozen bottle of water in the tea because over the summer the tea had become sour tasting. They had commercial frozen stick cylinders they put in the pitchers of white and chocolate milk when they were serving in the dining room. They ran the cylinders through the dishwasher. The bottle of water got washed every night and refilled, it was just stained from the tea. The residents' snack refrigerator was observed on 01/28/2026 at 12:22 P.M., with RN 2 and contained the following: -A Styrofoam meal container, dated 01/20/2026, in a plastic grocery bag, the RN indicated was for a resident who was admitted from another facility over the weekend, and -A small, sealed snack tray with no resident name, room number, or date. During an interview, on 01/28/2026 at 12:55 P.M., the Administrator indicated they did not have a policy related to staff personal items in the kitchen food prep area. The INDIANA DEPARTMENT OF HEALTH Retail Food Establishment Sanitation Requirements for 2025 indicated, .Sec. 118. (a) Single-use articles means utensils and bulk food containers designed and constructed to be used once and discarded.The term includes items, such as.jars.plastic tubs or buckets.bottles. The current Food from Outside Sources policy, with a revised date of 07/2023, was provided following the Entrance Conference. The policy indicated, .Visitors/family members will label food and beverages with the resident's name, room number, and date.Perishable foods with a use by date which is 3 days from the date that it was brought into the facility. 3.1-(i)(3)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview and record review, the facility failed to obtain a resident's ordered blood tests for 1 of 5 residents reviewed for laboratory services. (Resident 9)Findings include:Resident 9's clinical record was reviewed on 01/21/2026 at 2:49 P.M. A Quarterly Minimum Data Set (MDS) assessment, dated 01/06/2026, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, anemia (deficiency of health red blood cells), hypertension (high blood pressure), hypothyroidism (under active thyroid), and seizure disorder (neurological condition characterized by recurrent unprovoked seizures). The resident's current medication orders included, but were not limited to, the following:- An open-ended physician's order, with a start date of 07/10/2025, for Synthroid, 25 Micrograms daily for hypothyroidism.- An open-ended physician's order, with a start date of 07/10/2025, for Depakote Sprinkles capsules, 500 milligrams twice a day for a seizure disorder.The resident's current physician's orders included an open-ended order, with a start date of 10/15/2024, to obtain the following blood tests every six months, in September and March:- Depakote level, - Complete Metabolic Panel (CMP),- Complete Blood Count (CBC), - Thyroid Stimulating Hormone (TSH),- Free Thyroxine level (T4), and - Hemoglobin A1C (a test that measured the average blood sugar levels over the past three months).The resident's record lacked blood test results for Depakote levels, TSH, T4, and A1C levels that should have been obtained in March 2025 and September 2025.During an interview, on 01/28/2026 at12:52 P.M., the DON indicated the resident's Depakote, TSH, T4, and A1C blood tests were not obtained in March 2025 and September 2025. The blood tests were missed and should have been completed. The current Lab and Diagnostic Test Results - Clinical Protocol with a revision date of November 2018, was provided by the DON on 01/28/2026 at 12:44 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)