

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155324	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/17/2013
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NAME OF PROVIDER OR SUPPLIER MITCHELL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/17/13</p> <p>Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist and Steven Schwing, Life Safety Code Specialist Trainee</p> <p>At this Life Safety Code survey, Mitchell Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all</p>	K010000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

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	<p>resident sleeping rooms. The facility has a capacity of 171 and had a census of 64 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 07/19/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>						

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K010038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 17 exit doors with electromagnetic locks remained unlocked until the fire alarm system was reset. LSC 7.2.1.6(d) requires doors shall automatically unlock and remain unlocked until the fire protective signaling system has been manually reset. This applies to electromagnetic locks on all doors to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect 16 residents on B hall as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 07/17/13 at 3:10 p.m. during a fire alarm test with the Maintenance Supervisor the electromagnetic locks on north and south</p>	K010038	<p>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 please1) The fire alarm system is inspected quarterly and the most recent inspection and test was on June 19th, 2013 in accordance to LSC 9.6.1.4 and showed all systems, including the electromagnetic locks, were working properly.2) The 2 electromagnetic locks found to remain unlocked on</p>	07/31/2013			

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	<p>Service hall which was adjacent to B hall did not release upon activation of the fire alarm system. Based on interview on 05/22/13 at 3:30 p.m. it was acknowledged by the Maintenance Supervisor the aforementioned exit doors equipped with electromagnetic locks remained locked when the fire alarm system was activated.</p> <p>3.1-19(b)</p>		<p>7/17/13, were fixed and all exit doors were inspected and tested on 7/25/13, and found in good working order.3) Maintenance will ensure a visual inspection of all electromagnetic doors is completed when performing the quarterly fire alarm system inspections by touring with Inspection Company.4) The Safety Committee will review quarterly for the next 2 quarters, fire alarm system inspections; to ensure a visual walk through was completed.</p>		

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire resistive enclosure. This deficient practice could affect 16 residents on B wing as well as visitors and staff near the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 07/17/13 at 1:23 p.m. with the Maintenance Supervisor, the door to the Oxygen transfer room adjacent to B wing did not have a manufacturer's tag which could identify it as a forty five minute fire rated door. Based on interview on 07/17/13 at 1:25 p.m., it was acknowledged by the</p>	K010143	<p>1) The door to the oxygen transfer room will be replaced by 7/31/13 with a fire rated door of 90 minutes, evidence by the manufactures tag present on the door.2) Maintenance will ensure tag remains on door during monthly rounds through the preventative maintenance program monthly checklist.3) Findings of rounds will be reviewed monthly during Safety meetings for 6 months and annually thereafter.</p>	07/31/2013			

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	Maintenance Supervisor oxygen transfer occurs in the Oxygen storage room and the fire rating of the corridor door to the oxygen transfer room was unknown and could not be verified. 3.1-19(b)				