STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 01 B. WING	09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	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). Survey Date: 09/11/15 Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590 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. This one story facility, consisting of Building 0101 and Building 0202 each constructed prior to 2003, was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke	K 0000	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 please	

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

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	detectors in all resident sleeping rooms. The facility has a capacity of 171 and had a census of 53 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached garage and two storage barns providing facility storage services which were not sprinklered. Quality Review completed on 09/14/15 - DA			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 15 residents, staff and visitors in the vicinity of Room 173. Findings include:	K 0025	K025 1.Themissing escutcheon for the bathroom in resident room 173 has been replaced. 2.A100% facility audit has been completed and no other missing escutcheons havebeen identified. 3.Quarterlytours evaluating for presence of escutcheons will be conducted by theMaintenance	10/09/2015

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	Based on observation with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, the escutcheon was missing for the automatic sprinkler located in the bathroom for Room 173 in the D Wing which left a three inch hole in the ceiling and exposed the attic above. Based on interview at the time of observation, the Director of Maintenance acknowledged the escutcheon for the aforementioned automatic sprinkler was missing which left a three inch hole in the ceiling and exposed the attic above. 3.1-19(b)		Director or designee. Anymissing escutcheons will be replaced at time of tour. 4. Documented results of quarterly escutcheontours will be presented to the QI committee quarterly for 12 months.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 20 hazardous areas such as fuel fired heater rooms were separated from other areas by self closing	K 0029	K029 1.Theentry door to the furnace room near the lower dining room has been fitted witha self-closing	10/02/2015

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	doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the furnace room by the Lower Dining Room. Findings include: Based on observation with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, the corridor entry door to the furnace room by the Lower Dining Room which contained one natural gas fired furnace was not equipped with a self closing device. Based on interview at the time of observation, the Director of Maintenance acknowledged the corridor entry door to the furnace room by the Lower Dining Room was not equipped with a self closing device. 3.1-19(b)		device. 2.A100% facility audit has been completed and all other hazardous areas have beenfitted with self-closing devices. 3.Quarterlytours evaluating for presence of self-closing devices on doors to hazardousareas will be conducted by the Maintenance Director or designee. Any doors to hazardous areas with missing ornon-functional self-closing devices will be corrected. 4. Documented results of quarterly hazardous roomself-closing devices audit will be presented to the QI committee quarterly for12 months.	
K 0046 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on record review, observation and interview; the facility failed to document monthly functional testing of emergency lighting in accordance with LSC 7.9 for	K 0046	K046 1.Themonthly emergency lighting test logs will be updated to ensure that theyinclude both	10/02/2015

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	all battery powered lights. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Lighting: check illumination of exit lighting and exit signs" and "TELS Work Schedule Tasks for Next Week: emergency lighting conduct a 30 second functional test" preventive maintenance documentation with the Executive Director and the Director of Maintenance during record review from 9:10 a.m. to 11:20 a.m. on 09/11/15, documentation of an itemized listing of monthly functional testing for not less than 30 seconds for each battery powered emergency light in the facility within the most recent twelve month period was not available for review. The aforementioned documentation stated all exit lights were tested as the results of monthly functional testing. Based on		the location of each light tested and the duration that each lightwas tested. 2. Step 1 corrective action addresses issue forall residents in facility. 3.Maintenancestaff will be trained to use the updated emergency lighting test logs and logbooks will be updated accordingly. 4.EDand Maintenance Director or designee will review emergency lighting test logsquarterly.	

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	interview at the time of record review, the Director of Maintenance acknowledged an itemized listing of the location and results of monthly functional testing for not less than 30 seconds for the most recent twelve month period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, a total of four battery powered emergency lights were observed installed in the facility and each light operated when its respective test button was pushed. 3.1-19(b)			
K 0052 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 1. Based on record review and interview, the facility failed to document annual testing of the facility fire alarm system. NFPA 72, 7-3.2 refers to fire alarm component testing frequencies in Table 7-3.2 which requires an annual fire alarm system test. Section 7-5.2 requires a permanent record of all inspections,	K 0052	K052 1.The facility alleges that fire alarm systems and smoke detectors were tested incompliance with the NFPA 72, 7-5.2 at the time of our survey. Documents from our fire system contractor have been obtained showing that the fire system and smoke detectors were tested in a	09/15/2015

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	testing and maintenance shall be provided that includes information requested in Figure 7-5.2.2. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of SafeCare's "Inspection & Testing Form" documentation dated 09/29/14 with the Executive Director and the Director of Maintenance during record review from 9:10 a.m. to 11:20 a.m. on 09/11/15, documentation of annual testing of all fire alarm system initiating devices was not available for review. The "Comments" section of the aforementioned report stated "Tested one smoke and one pull" and did not state the location and results of testing all fire alarm system initiating devices. Based on interview at the time of record review, the Executive Director stated documentation of additional fire alarm system initiating devices testing within the most recent twelve month period was not available for review and acknowledged documentation of annual testing of all fire alarm system initiating devices was not available for review. 3-1.19(b)		manner consistent with NFPA 72, 7- 3.2 and that tests were performed within the required time frames. We are also submitting evidence that the smoke detectors which failed sensitivity testing on 3/18/15 had been replaced prior to the 9/11/15 LSC survey. Documentation received from fire system contractor showing detailed listing of devices tested during both fire system inspection and smoke detector sensitivity testing as well as subsequent corrective action will be maintained on file within the facility for future review. 2. Comprehensive fire system and smoke detector testing will continue as required by NFPA 72, 7-5.2. Deficiencies identified will be corrected by fire system provider in a timely manner. 3.Upon receipt, the Maintenance Director or designee will review testing reports from fire system contractors to ensure that reports include detailed listing of devices tested. Reports will be maintained along with other fire system documents. 4.ED and Maintenance Director or designee will review testing reports to ensure they feature detailed listing of devices tested when they meet to review annual fire system inspection results.	

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	2. Based on record review, observation and interview; the facility failed to ensure all smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit			

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	arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of SafeCare's "Service Call Report" documentation dated 07/30/14 and "Inspection & Testing Form" documentation dated 09/29/14 with the Executive Director and the Director of Maintenance during record review from 9:10 a.m. to 11:20 a.m. on 09/11/15, smoke detector sensitivity testing documentation for the most recent two year period for all facility fire alarm system smoke detectors was not available for review. SafeCare's 09/29/14 documentation stated there are 88 fire alarm system smoke detectors installed in the facility one of which was functional tested only. SafeCare's 07/30/14 listed the sensitivity testing results for 15 smoke detectors which had been recently installed. Based on interview at the time			

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	of record review, the Executive Director acknowledged documentation of smoke detector sensitivity testing within the most recent two year period for all fire alarm system smoke detectors was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, smoke detectors hard wired to the fire alarm system were observed installed in the corridors and in all areas open to the corridor. 3.1-19(b)			
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads was maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 15 residents, staff and visitors in the vicinity of Room 173. Findings include:	K 0062	K062 1.Themissing escutcheon for the bathroom in resident room 173 has been replaced. 2.A100% facility audit has been completed and no other missing escutcheons havebeen identified. 3.Quarterlytours evaluating for presence of escutcheons will be conducted by theMaintenance Director or designee. Anymissing escutcheons will be replaced at	10/09/2015

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	Based on observation with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, the escutcheon plate was missing for the automatic sprinkler located in the bathroom for Room 173 in the D Wing which left a three inch hole in the ceiling and exposed the attic above. Based on interview at the time of observation, the Director of Maintenance acknowledged the escutcheon plate for the aforementioned automatic sprinkler was missing which left a three inch hole in the ceiling and exposed the attic above. 3.1-19(b)		time of tour. 4. Documented results of quarterly escutcheontours will be presented to the QI committee quarterly for 12 months.	
K 0130 SS=F Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 83 of 83 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0130	K130 1.Thefacility alleges that battery operated smoke detectors in resident rooms werebeing maintained and cleaned in accordance with LSC 4.6.12.2. Battery operated smoke detector maintenancelogs have been updated to show itemized listing of detectors tested and cleanedon a monthly basis. Documentationshowing itemized listing of tested / cleaned battery operated smoke detectorswill be maintained on file for future review.	10/02/2015

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	Based on review of "Direct Supply TELS: Test all battery operated smoke detectors in resident rooms per manufacturer's recommendation" documentation with the Executive Director and the Director of Maintenance during record review from 9:10 a.m. to 11:20 a.m. on 09/11/15, an itemized listing of battery operated smoke detector testing and cleaning by location for the 52 week period of 08/11/14 through 08/17/15 was not available for review. The results of testing battery operated smoke detectors in resident sleeping rooms are documented as being all were tested on a weekly basis. In addition, documentation of an itemized list of monthly battery operated smoke detector cleaning by location was not available for review. Based on review of Family Gard "Battery Operated Smoke Alarm Model FG200" manufacturer's instruction manual, battery operated smoke detectors shall be cleaned once per month by gently using a vacuum cleaner. Based on interview at the time of record review, the Executive Director and the Director of Maintenance acknowledged an itemized listing of battery operated smoke detector testing and cleaning by location for the most recent 52 week period was not available for review. Based on observations with the Director		2.Stepone corrective action addresses battery operated smoke detector maintenance andcleaning documentation needs for entire facility. 3.Maintenancestaff will be trained to use the updated battery operated smoke detectortesting / cleaning logs and log books will be updated accordingly. 4.EDand Maintenance Director or designee will review battery operated smokedetector testing / cleaning logs quarterly.	

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	of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, Family Gard Model FG200 battery operated smoke detectors are installed in each of 83 resident sleeping rooms in the facility. Based on interview at the time of the observations, the Director of Maintenance stated housekeeping staff clean the aforementioned smoke detectors with a dusting brush but acknowledged monthly battery operated smoke detector cleaning documentation was not available for review. 3.1-19(a)9(a)			
K 0051 SS=E Bldg. 02	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of			

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	the fire alarm system to an approved central station. 19.3.4, 9.6 Based on observation and interview, the facility failed to install 3 of 25 manual fire alarm box initiating devices in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, section 2-8.1 states each manual fire alarm box shall be securely mounted and the operable part of the fire alarm box shall be not less than 3 1/2 feet and not more than 4 1/2 feet above the floor. Each installed initiating device shall be accessible for periodic maintenance and testing. This deficient practice could affect 14 residents, staff and visitors in the Pathways Wing. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 11:20 a.m. to 2:10 p.m. on 09/11/15, the operable part of three manual fire alarm boxes located in the Pathways Wing were each mounted on the wall 59 inches above the floor. The aforementioned three manual fire alarm box locations were at the north and south Pathways Wing exits by the Upper Dining Room and at the exit by Room 212. Based on interview at the time of the observations, the Maintenance Director acknowledged the operable part	K 0051	K051 1.The3 pull stations on the Pathways Wing that measured 59 inches above the floorhave been lowered to between 3 ½ and 4 ½ feet above the floor. 2.A100% facility audit has been completed and all other pull stations areappropriate heights from the floor. 3.Annualtours evaluating for proper placement of fire alarm pull stations will beconducted by the Maintenance Director / designee / or fire system contractor. 4. Documented results of annual pull stationplacement audits will be kept with annual fire systems inspectiondocumentation. ED and Maintenance Director or designee will review auditresults when annual fire system inspection results are reviewed.	10/09/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 02 B. WING	09/11/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL MANOR	24 TEKE BURTON DR MITCHELL, IN 47446

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	of the aforementioned three fire alarm boxes were each mounted on the wall more than 4 1/2 feet above the floor. 3.1-19(b)			