

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024

FORM APPROVED

OMB NO. 0938-039

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 04/15/2024	
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 04/15/24</p> <p>Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590</p> <p>At this Emergency Preparedness survey, Mitchell Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 171 certified beds. At the time of the survey, the census was 55.</p> <p>Quality Review completed on 04/17/24</p>			E 0000	<p>The creation of this letter of credible allegation constitutes Mitchell Manor's written allegation of compliance. Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an allegation admission of interest against the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency.</p> <p>This facility is respectfully requesting desk review:</p>		
K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 04/15/24</p> <p>Facility Number: 000217</p>			K 0000	<p>The creation of this letter of credible allegation constitutes Mitchell Manor's written allegation of compliance. Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kathi Hignite Owens

Executive Director

04/25/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-039

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 04/15/2024	
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 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 0321 SS=E Bldg. 01	<p>Provider Number: 155324 AIM Number: 100289590</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 483.90(a), Life Safety from Fire and the 2012 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 (000) construction and 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 resident sleeping rooms. The facility has a capacity of 171 and had a census of 55 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 04/17/24</p> <p>NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or</p>				<p>to be construed as an allegation admission of interest against the facility, the administrator, or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency.</p> <p>This facility is respectfully requesting desk review:</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-039

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 04/15/2024	
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.</p> <p>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 17 hazardous areas such as laundry rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect five residents, staff and visitors in the vicinity of the Laundry room.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility at 3:36 p.m. on 04/15/24, the corridor door to the Laundry room by the fuel fired dryers failed to latch into the frame when it self closed. The corridor door was tested five times from the fully open position and it failed to latch each time. Based on interview at</p>			K 0321	<p>K321 NFPA 101 Hazardous Areas-Enclosure It is the intent of this facility to have self-closing doors from the corridor into hazardous areas.</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice;</b></p> <p>No residents were affected by the alleged deficient practice. The self- closing door into the Laundry Areas was repaired and closes automatically.</p> <p><b>How will you identify other residents having the potential to be affected by the same</b></p>		04/24/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-039

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 04/15/2024
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0345 SS=C Bldg. 01	<p>the time of the observations, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors and stated he would work on the door and make sure it latches.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program</p>		<p><b>deficient practice and what corrective action will be taken.</b> Residents that reside at the facility may be affected by the alleged deficient practice. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.</b> Maintenance Supervisor will ensure all self-closing doors close properly, and immediate measures will be taken to correct any door that does not meet the standard. Staff have been educated on 4/22/24 to report any self-closing door not properly closing to the maintenance supervisor for repair. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</b> Maintenance Director/Designee will check all self-closing doors weekly to ensure proper closing. Audits will be forwarded to Quality Assurance Performance Improvement Committee x 6 months to ensure continuing compliance.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155324		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED 04/15/2024	
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 24 TEKE BURTON DR MITCHELL, IN 47446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.</p> <p>9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72</p> <p>Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time, date, and year information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on observations made with the Maintenance Director during a tour of the facility on 04/15/24 at 3:10 p.m., the facility fire alarm control panel had the incorrect time and date. At 3:10 p.m. on 04/15/24 the fire alarm control panel displayed 06/13/23 and 9:11 p.m. Based on an interview at the time of observation, the Maintenance Director indicated he was unaware of the discrepancy and would contact the alarm company to have the displayed date and time corrected as soon as he could.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>			K 0345	<p><b>F345 Fire Alarm System.</b> It is the intent of this facility that fire alarm system is tested and maintained in accordance NFPA 70.</p> <p><b>What corrective action(s) will be accomplished for these residents found to have been affected by the deficient practice;</b> On 4/18/24, a professional service provider came to the facility to correct the date and time on the fire alarm control panel.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All residents have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</b></p> <p>Preventative Maintenance checklist has been modified to include check of accurate date and time on fire alarm control</p>		04/24/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-039

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 04/15/2024	
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0353 SS=E Bldg. 01	<p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure all sprinkler heads at the nurse station were clean, free of foreign materials, and</p>			K 0353	<p>panel monthly. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b> Monthly PM checks verifying accurate date and time on fire alarm control panel will be submitted to Quality Assurance Performance Improvement Committee monthly x 6 months to ensure continuing compliance.</p> <p>K353 Sprinkler System It is the intent of this facility to ensure all sprinkler heads are clean, free of</p>		04/24/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2024  
FORM APPROVED  
OMB NO. 0938-039

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 04/15/2024	
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR				STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	<p>corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect over 15 residents and 5 staff in the vicinity of the nurse's station.</p> <p>Findings include:</p> <p>Based on observations made with the Maintenance Director during a tour of the facility on 04/15/24 at 3:27 p.m., a sprinkler head at the nurse's station on the A Hall side was loaded with dust so that the glass bulb was not visible. This was verified by the Maintenance Director at the time of the observation who stated that he would clean the loaded sprinkler head with compressed air as soon as possible.</p> <p>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.</p> <p>3.1-19(b)</p>				<p>foreign materials and corrosion. . <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>The sprinkler head at the nurse's station was cleaned by the maintenance director on 4/15/24 and the glass bulb is visible.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b> Residents that reside at the facility may be affected by the alleged deficient practice. <b>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Director was reinserviced on 4/19/24 regarding the need to ensure sprinkler heads are free of corrosion, foreign materials, paint and physical damage. Sprinkler heads will be checked via maintenance rounds weekly by Maintenance Director, to ensure that sprinkler heads are free of corrosion, foreign materials, paint and physical damage. Any irregularities will be addressed immediately.</p>		

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 04/15/2024
NAME OF PROVIDER OR SUPPLIER  MITCHELL MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 24 TEKE BURTON DR MITCHELL, IN 47446		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	
			<b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b>  These audits will be forwarded to monthly Quality Assurance Performance Improvement Committee to ensure that compliance is achieved, for 6 months or as indicated by the QA committee.		