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	03/25/2025

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

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/25/25 Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590 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. The facility has 171 certified beds. At the time of the survey, the census was 55. Quality Review conducted on 03/28/25	E 0000	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. This facility is respectfully requesting desk review with date of compliance 4/7/2025	
K 0000 Bldg. 01	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). Survey Date: 03/25/25	K 0000	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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathi HIgnite Owens	Executive Director	04/10/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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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	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 483.90(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. 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. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review conducted on 03/28/25		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. This facility is respectfully requesting desk review with date of compliance 4/7/2025	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Based on observation and interview, the facility failed to ensure 1 of over 5 heat detectors were installed properly. LSC 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72 2010 edition 29.8.5 states the installation of wiring and equipment	K 0341	It is the intent of this facility that a fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72. What corrective action will be accomplished for those residents	04/07/2025

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	shall be in accordance with the requirements of NFPA 70, National Electrical Code. This deficient practice could affect 12 residents, staff and visitors. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/25/25 at 1:55 p.m., the heat detector located on the ceiling of the mechanical room that housed the sprinkler riser was hanging down by it's connected wires. Based on interview at 1:57 p.m. with the Maintenance Director, he confirmed that the heat detector on the ceiling was not installed properly and was hanging down from the mounted base. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		found to have been affected by alleged deficient practice. The identified heat detector that had fallen was secured by the maintenance director and in proper position during the survey. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken: The identified heat detector that had fallen was secured by the maintenance director and in proper position during the survey. What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur: The identified heat detector that had fallen was secured by the maintenance director and in proper position during the survey. To enhance currently compliant operations and under the direction of the maintenance director a monthly audit will be conducted of the five heat detectors to ensure proper placement x 6 months. How the corrective action will be monitored to ensure the alleged deficient practice will not recur: Findings from the heat detector audits will be submitted to the Quality Assurance Performance Improvement Committee x 6 months to ensure continuing	

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			compliance. The Executive Director is responsible for this plan of correction.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 GFCI outlets in the C Wing spa room was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect 10 residents and staff in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/25/25 at 1:48 p.m., the coverplate for the GFCI outlet at the sink in C Wing spa room was missing. Based on interview at 1:49 p.m., the Maintenance Director confirmed the outlet was missing a coverplate and that exposed wiring was visible. A coverplate was installed on the GFCI outlet prior to survey exit. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0511	It is the intent of this facility that equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, 2011 edition regarding electrical GFCI outlet covers. What corrective action will be accomplished for those residents found to have been affected by alleged deficient practice: The cover plate for GFCI outlet located at the sink in C Wing spa room was replaced during the survey as indicated in the statement of deficiencies. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken: The cover plate for GFCI outlet located at the sink in C Wing spa room was replaced during the survey as indicated in the statement of deficiencies. No residents were affected. What measures will be put into place and what systemic changes will be made to ensure the alleged deficient practice does not recur.	04/07/2025

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			To enhance currently compliant operations and under the direction of the maintenance director GFCI outlets located in spa rooms will be observed monthly x 6 months ensure plate covers remain in place. How the corrective action will be monitored to ensure the alleged deficient practice will not recur. Audits of the GFCI plate covers will be forwarded to the Quality Assurance Performance Improvement Committee monthly x 6 months to ensure continuing compliance. The Executive Director is responsible for this plan of correction.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure 1 of 1 non-smoking area was maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect 20 residents, staff and visitors near the exit between A and B Wing. Findings include: Based on observation with the Maintenance Director on 03/25/25 at 2:35 p.m., discarded cigarette butts were located on the ground outside the exit located between A and B Wing by the nurse station. There were approximately 40 cigarette butts on the ground by the building and landscaping. Cigarette butts were observed mixed	K 0741	It is the intent of this facility that smoking regulations shall be adopted and shall include, not less than the following provisions ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. What corrective action will be accomplished for those residents found to have been affected by alleged deficient practice: An ashtray of noncombustible material was placed outside the exit located between A & B Wing by the nurses station for visitors to dispose of smoking materials	04/07/2025

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	in with the trash of the trash can by the exit. Remnants of ash was on the brick wall at the exit door and top of the trash can where cigarettes had been snuffed out. Two signs attached to the exterior wall by exit door read 'State law prohibits smoking within 8 feet of this building' and 'This is a Non-Smoking property.' There were two metal folding chairs and four milk crates on either side of the exit door. There are no metal or non-combustible container in the area. Based on an interview at 2:40 p.m., the Maintenance Director stated this area is not a designated smoking area, agreed there are cigarette butts on the ground outside of the exit. The Maintenance Director stated that staff are aware this is not a designated smoking area and it has been an ongoing issue of smoking taking place outside the A and B Wing exit by the nurse station. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)		safely and at least 8 feet from the building. Sign indicating a non smoking property was removed. Folding chairs and milk crates were removed. Cigarette butts were cleaned up. Under the direction of the Executive Director. Staff were inserviced on smoking only in designated smoking area in rear of building. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken: An ashtray of noncombustible material was placed outside the exit located between A & B Wing by the nurse's station for visitor to dispose of smoking materials safely and at least 8 feet from the building. To enhance currently compliant operations and under the direction of the Executive Director, staff were inserviced on smoking only in designated smoking area in rear of building. What measures were put into place and what systemic changes will be made to ensure that the alleged deficient does not recur: Under the direction of the Maintenance Director/Designee a daily audit will be conducted x 5 days, weekly x 2 months and monthly x 4 months to ensure smoking is occurring in the designated area only and that	

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			proper waste receptacles are in place. How the corrective action will be monitored to ensure the alleged deficient practice does not recur: Audits will be submitted to the Quality Assurance Performance Improvement Committee monthly x 6 months to ensure continuing compliance. The Executive Director is responsible for this plan of correction.	