STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING -- B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILNER COMMUNITY HEALTH CARE	370 E MAIN ST ROSSVILLE, IN 46065

(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. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/10/24 Facility Number: 000299 Provider Number: 155676 AIM Number: 100286940 At this Emergency Preparedness survey, Milner Community Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 52. Quality Review completed on 09/11/24	E 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance. We are respectfully requesting a desk review/paper compliance.	
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: 09/10/24 Facility Number: 000299 Provider Number: 155676 AIM Number: 100286940	K 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
richard g jackson	administrator	09/26/2024

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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	At this Life Safety Code survey, Milner Community Health Care 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) and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a two-hour separation from an assisted living occupancy located on the west side of the building. The west emergency exit from A Hall requires passing through the assisted living Dining \ Activities room. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and in all resident rooms. The facility has a capacity of 80 and had a census of 52 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for the one detached storage shed and one garage storage area which are not sprinklered. Quality Review completed on 09/11/24		Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance. We are respectfully requesting a desk review/paper compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 2 of 4 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following	K 0211	1. Night stand was placed on wheels. 2. Covid isolation has been completed. All barrels and cabinets have been removed from	10/07/2024

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	conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 18 residents, 4 staff and 2 visitors. Findings include: Based on observations made with the Maintenance Director on 09/10/24 from 11:25 a.m. to 1:35 p.m. during a tour the facility the following was noted: a) There were two large 45-gallon trash containers being stored in the corridor immediately outside resident room # A5. b) There was a wooden table being stored in the corridor immediately outside resident room # B1. This table was not on wheels. c) There were five large 45-gallon trash containers being stored in the corridor immediately outside resident rooms # B5, # B7, and # B9. Based on interview with the Maintenance Director at the time of each observation, he confirmed the trash containers were being stored in the corridor and were not in use at the time of each observation. He furthermore added that he thought the table was on wheels, but when checked, it was confirmed that it was not. This item was discussed again with the		hallways. 3. Environmental Service Director will monitor halls during Covid outbreaks to ensure all barrels and cabinets are on wheels. 4. QAA will discuss during outbreaks to ensure proper procedures are being followed.	

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	Administrator and the Maintenance Director at the exit conference on 09/10/24 at 2:20 p.m. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1.1 Delayed-Egress Locking Systems allows approved, listed, delayed-egress locks shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (1) The door leaves shall unlock in the direction of egress upon activation of one of the following: (a) Approved, supervised automatic sprinkler system installed in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detections system in accordance with section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the	K 0271	1. Door was adjusted immediately. 2. All other similar doors were checked and adjusted. 3. Director of Environmental Services will place on weekly preventative maintenance for 3 months and then will move to monthly checks. 4. Maintenance Director will report results to QAA committee for one year to assure compliance.	10/07/2024

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	release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) A readily visible, durable sign in letters not less than 1 in. (25mm) high and at least 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". (5) The egress side of the doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with 7.9. This deficient practice could affect as many as 12 residents, 4 staff, and 2 visitors. Findings include: Based on observations made with the Maintenance Director on 09/10/24 from 11:25 a.m. to 1:35 p.m. during a tour the facility the following was noted: a) The 15 second delay function on the door from the Long-Term Care building leading to the Assisted Living area of the facility failed to open when tested. The door was pushed on several times, but the irreversible process to release the lock in the direction of egress within 15 seconds never started. b) The 15 second delay function on the door			

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	nearest to the Business office failed to open when tested. The door was pushed on several times, but the irreversible process to release the lock in the direction of egress within 15 seconds never started. c) The 15 second delay function on the door nearest to the Beauty shop failed to open when tested. The door was pushed on several times, but the irreversible process to release the lock in the direction of egress within 15 seconds never started. Based on an interview at the time of each observation, the Maintenance Director agreed that both aforementioned doors failed to begin the irreversible process to release the lock and stated that he would have both doors looked at as soon as possible. This item was discussed again with the Administrator and the Maintenance Director at the exit conference on 09/10/24 at 2:20 p.m. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as a soiled linen room was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 12 residents, 4 staff, and 2 visitors in the facility. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 11:5a a.m.,	K 0321	1. Removed obstruction from door immediately. 2. All similar doors were checked to assure compliance. 3. Door in question will have a keypad installed. Staff will be in-serviced on door obstruction issues, including reporting violations. 4. Environmental Serices Manager will report to QAA committee quarterly for 1-year issues of noncompliance.	10/07/2024

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	the corridor door to the storage room nearest to the Assisted Living entrance, a hazardous room greater than 50 square feet in size doors was equipped with a self-closing device, but the door would not latch because someone had jammed paper towels into the door strike causing to door to stay propped in the open position. Based on interview at the time of observation, the Maintenance Director acknowledged the corridor door to the aforementioned hazardous area being held open by paper towels being jammed into the door strike adding that he would have to speak to or educate staff about not doing this in the future. This item was discussed again with the Administrator and the Maintenance Director at the exit conference on 09/10/24 at 2:20 p.m. 3.1-19(b)			
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Based on record review, observation, and interview; the facility failed to ensure materials used as an interior finish in 1 of 7 smoke compartments had a flame spread rating of Class A or Class B. LSC 101 10.2.3.4 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame	K 0331	1. Siding was taken off and replaced with drywall. 2. All other areas have been checked to ensure compliance. 3. Environmental Services Director will ensure proper materials are being utilized during any construction. 4. QAA will follow for 3 months during any construction activities to ensure compliance.	10/07/2024

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	spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect up to 17 residents, staff, and visitors while in the same smoke compartments. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 1:25 p.m. during a tour of the facility, the service hall had vinyl siding on the walls as it was once a part of the outside of the building before that hall was enclosed with a doorway. During records review, there was a part of the Life Safety Code binder containing flame spread ratings of the materials within the facility, but nothing could be located in reference to the vinyl siding. When asked if there were flame spread documents for the vinyl siding located in the Service hall, the Maintenance Director stated that he thought there might be. An interview during the exit conference again brought up the vinyl siding flame spread rating documentation question, but none could not be located or provided at that time. At that time it was determined that the vinyl siding would be cited for the purposes of this survey. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 2 foyers in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 12 residents, 4 staff, and 2 visitors. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 1:25 p.m. during a tour of the facility, the foyer area entrance on the west end of the facility had two ceiling fans therein. The blades to these fans were mounted as such that they were only six inches from the ceiling fan blades, and they would definitely obstruct the spray pattern on the sprinklers in the event of a fire. Based on interview at the time of observation, the Maintenance Director stated that the fans were added to the foyer after all the new sprinkler heads were installed last year and he did not know about the need for the 18 inches of clearance for the sprinkler head spray patterns to function properly. This finding was reviewed with the Executive	K 0351	1. Sited fan was removed. 2. Other area was cleared. 3. Environmental Services Director will check with facilities sprinkler system management company to review any future areas to assure nothing is placed that would cause obstruction. 4. QAA committee will review any future recommendations.	10/07/2024

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	Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure access and working space was maintained in 1 of 1 Assisted Living Dining / Activities storage room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect 12 residents, 4 staff and 2	K 0511	1. All items have been removed from cited area. 2. All electrical panels were checked to ensure ease of access. 3. Maintenance department was in-serviced by Administrator on proper compliance to panels. 4. Administrator or designee will check quarterly for 1 year and report to QAA any findings.	10/07/2024

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	visitors. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 1:25 p.m. during a tour of the facility, three electrical panels were located on the wall in the Assisted Living Dining / Activities storage room. A fan, tools, and a small work cart were all stored within three feet of the electrical panels. Based on interview at the time of the observations, the Maintenance Director stated that he was sure his Assistant was currently working on things within the room, agreed there were items stored directly in front of the electrical panels that could limit quick access in the event of an emergency, and stated the items will be removed as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on record review, observation and interview, the facility failed to provide ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 2 outdoor areas where smoking is permitted. This deficient practice could affect 2 resident and 1 staff. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 12:34 p.m.	K 0741	1. Smoking area was immediately cleaned. 2. All smoking areas were checked for cigarette butts and cleaned as needed. 3. Smoking policy was reviewed. All staff will be in-serviced on smoking policy. Environmental Services Director will put on weekly maintenance calendar to ensure areas are properly	10/07/2024

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	during a tour of the facility, the B Hall smoking area had numerous cigarette butts laying on the ground. Based on interview at the time of observation, the Maintenance Director acknowledged the cigarette butts and added that he provides a smoker's tower and other approved devices to try and keep the smokers from dropping their cigarette butts on the ground, but they just don't want to cooperate with him sometimes adding that he would have the area and cigarette butts picked up as soon as possible. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		maintained. 4. Environmental Services Director will report quarterly to QAA to review compliance.	
K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Based on observation and interview; the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect 3 staff in the Business office. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 12:21 p.m. during a tour of the facility, the Business office had a portable space heater plugged into a wall outlet in it. When asked if it was just a fan or if it "made heat" the staff answered that it was indeed a portable space heater is it gets very cold in the Business office in the mornings. The Maintenance man then explained that portable space heaters were not allowed to be in use in the building. Based on an interview at the time of the observation, the Maintenance Director agreed	K 0781	1. Portable heater was removed from bookkeeping office immediately. 2. All offices were checked to assure no space heaters were found. 3. Policy was reviewed and all staff in-serviced on policy. 4. Environmental Services Director will check monthly to assure no space heaters in use and will report to QAA quarterly for 1 year.	10/07/2024

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	that there was a portable space heater in the Business office, that it was plugged into a wall outlet, and the use of portable space heaters in the facility was prohibited. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 2 foyers did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring, and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect as many as 4 residents, 2 staff and 1 visitor. Findings include: Based on observations made with the Maintenance Director on 09/10/24 at 11:25 p.m. during a tour of the facility, there was a yellow 50-foot extension cord plugged into a window mounted air conditioned in the main entrance foyer. Based on interview at the time of the observation, the Maintenance Director acknowledged the extension cord and removed it from the wall stating that he felt an in-service may be necessary to make staff aware that the use of extension cords is not allowed in a health care facility.	K 0920	1. Extension cord was removed from cited area. 2. All window A/C's were checked to ensure proper electric source. 3. Environmental Services Director will ensure all window A/C's will have proper electric source. All-staff will be in serviced on use of extension code usage. 4. Environmental Services Director will report to QAA any new A/C units installed has been checked to ensure compliance for 1 year.	10/07/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 01 B. WING	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILNER COMMUNITY HEALTH CARE	370 E MAIN ST ROSSVILLE, IN 46065

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	This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			