CENTERS FUR	C MEDICAKE & MEDIC				OMB NO. 0936-039	
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<del></del>	COMPLETED	
		155691	B. WING		06/16/2025	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	R		WASHINGTON ST		
MORRIS	TOWN MANOR			ISTOWN, IN 46161		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
E 0000						
Bldg						
	An Emergency Pre	paredness Survey was	E 0000	Please find enclosed the Plan	of	
	conducted by the Ir	ndiana Department of Health in		Correction for the State Licens	sure	
	accordance with 42	CFR 483.73.		Survey conducted on June 16	,	
				2025. This letter is to inform y	/ou	
	Survey Date: 06/16	6/25		that the plan of correction		
				attached is to serve as Morrist	town	
	Facility Number: 0	000422		Manor'sy credible allegation o	f	
	Provider Number:	155691		compliance. We are requestir	ng	
	AIM Number: 100	291030		paper compliance for this plan	ı of	
				correction.		
	At this Emergency	Preparedness survey,				
	Morristown Manor	was found in compliance with		If you have any further question	ons,	
	Emergency Prepare	edness Requirements for		please do not hesitate to conta	act	
	Medicare and Medi	icaid Participating Providers		me at 765-763-6012.		
	and Suppliers, 42 C	CFR 483.73.				
				Sincerely,		
	The facility has 119	ertified beds. At the time of				
	the survey, the cens	sus was 98.				
				Andrew Buzzard, HFA		
	Quality Review cor	mpleted on 06/24/25		Administrator		
				Morristown Manor		
K 0000						
Bldg. 01						
	A Life Safety Code	Recertification and State	K 0000	Please find enclosed the Plan	of	
	Licensure Survey w	vas conducted by the Indiana		Correction for the State Licens	sure	
	Department of Hea	lth in accordance with 42 CFR		Survey conducted on June 16	,	
	483.90(a).			2025. This letter is to inform y	/ou	
				that the plan of correction		
	Survey Date: 06/16	5/25		attached is to serve as Morrist	town	
				Manor'sy credible allegation o	f	
	Facility Number: 0	000422		compliance. We are requestir	ng	
	Provider Number:	155691		paper compliance for this plan	ı of	
	AIM Number: 100	291030		correction.		

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

(X6) DATE

TITLE

Andrew Buzzard Administrator 07/07/2025

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KQGJ21 Facility ID: 000422 If continuation sheet Page 1 of 30

			, ,	LE CONSTRUCTION	f 1	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155691	A. BUILDIN B. WING	G <u>01</u>		COMPLETED 06/16/2025	
		155691			_	16/2025	
NAME OF P	PROVIDER OR SUPPLIER	8		EET ADDRESS, CITY, STATE, ZIP	COD		
MORRIS.	TOWN MANOR			S S WASHINGTON ST RRISTOWN, IN 46161			
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
IAG		Code survey, Morristown	IAC	If you have any furthe	r questions	DATE	
	-	ot in compliance with		please do not hesitate	-		
	Requirements for P	-		me at 765-763-6012.	, 10 00		
	-	, 42 CFR Subpart 483.90(a),					
	Life Safety from Fi	re and the 2012 edition of the		Sincerely,			
	National Fire Protect	ction Association (NFPA) 101,					
	Life Safety Code (L	LSC), Chapter 19, Existing					
	Health Care Occupa	ancies and 410 IAC 16.2.		Andrew Buzzard, HFA	4		
				Administrator			
	_	ity consists of Building 01		Morristown Manor			
		and the attached Cypress Run					
		as Building 02 constructed in					
		g was determined to be of Type n and fully sprinklered. The					
		arm system with smoke					
		ridor and in all areas open to					
		acility has smoke detectors					
		re alarm system installed in all					
		oms. The facility has a					
		had a census of 98 at the time					
	of this visit.						
		idents have customary access					
	-	The facility has three detached					
	storage buildings w	hich were each not					
	sprinklered.						
	O1' D						
	Quanty Review con	mpleted on 06/24/25					
K 0100	NFPA 101						
SS=E	General Requirem	nents - Other					
Bldg. 01	'						
	1. Based on observa	ation and interview, the facility	K 0100	K 100		07/21/2025	
		atching hardware on 2 of over 8					
		sets and on 1 of 1 Main		I. The corrective act			
		4.6.12.3. LSC 4.6.12.3 requires		accomplished for the			
		features obvious to the public		residents found to ha			
		ne Code, shall be either		affected by the defici	ient		
		ved. This deficient practice		practice.			
	could affect over 20	residents. staff and visitors.		Observation 1- The co	วmmunity		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 2 of 30

07/09/2025 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/16/2025 155691 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 868 S WASHINGTON ST MORRISTOWN MANOR MORRISTOWN, IN 46161 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure that the 3 different Findings include: fire door sets positively latched into the door frame. The Based on observations with the Maintenance Maintenance Supervisor has Supervisor at 12:58 p.m. on 06/16/25, each door in repaired all door sets so they the cross corridor door set by the Cypress Run latch. conference room was equipped with latching Observation 2- The community hardware to latch each door into the door frame failed to ensure that the oven in but the door set failed to latch into the door frame the south dining room was turned when tested to close multiple times. Each door in off when unattended. The the door set was also equipped with a wall Maintenance Supervisor shut the mounted magnetic holding device set to release oven off immediately. the door to close with fire alarm system activation. Based on observations with the Maintenance II. The facility will identify Supervisor at 1:02 p.m. on 06/16/25, each door in other residents that may the cross corridor door set by Room 601 was potentially be affected by the equipped with latching hardware to latch each deficient practice. door into the door frame but the door set failed to All staff and residents in the latch into the door frame when tested to close community have the potential to multiple times. Each door in the door set was also be affected by this deficient equipped with a wall mounted magnetic holding practice. device set to release the door to close with fire alarm system activation. Based on observations III. The facility will put into with the Maintenance Supervisor at 2:28 p.m. on place the following systematic 06/16/25, the corridor door set serving as the changes to ensure that the entrance to the Main Dining room by the main deficient practice does not entrance lobby was also equipped with latching hardware to latch each door into the door frame Observation 1-There is a current but each door failed to latch into the door frame weekly TELS task to inspect all when tested to close multiple times. Based on fire doors and resident doors to interview at the time of each of the observations, ensure they latch. See attached the Maintenance Supervisor agreed each of the TELS task labeled "Morristown three door set's latching hardware failed to latch Door Inspection TELS Task"

FORM CMS-2567(02-99) Previous Versions Obsolete

close multiple times.

during the exit conference.

each door into the door frame when tested to

Administrator and the Maintenance Supervisor

These findings were reviewed with the

KQGJ21 Event ID:

Facility ID: 000422

If continuation sheet

Observation 2- The community

that all ovens and cooking

not in use. See attached in-service paperwork.

held an in-service to educate staff

appliances that are accessible to

residents must be shut off when

Page 3 of 30

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

PRINTED: 07/09/2025 FORM APPROVED OMB NO. 0938-039

	of correction identification number 155691	A. BUILDING B. WING	01	COMPLETED 06/16/2025
	PROVIDER OR SUPPLIER TOWN MANOR	868 S W	.DDRESS, CITY, STATE, ZIP COD /ASHINGTON ST STOWN, IN 46161	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211	3.1-19(b)  2. Based on observation and interview, the facility failed to ensure 1 of 1 residential electric stove was not left powered on and unattended in the dining/activity room. LSC 19.1.1.2 states that the goals and objectives of Sections 4.1 and 4.2 shall be met with due consideration for functional requirements, which are accomplished by limiting the development and spread of a fire emergency to the room of fire origin and reducing the need for occupant evacuation, except from the room of fire origin. LSC 4.2.1 states that a structure shall be designed, constructed, and maintained to protect occupants who are not intimate with the initial fire development for the time needed to evacuate, relocate, or defend in place. This deficient practice could affect over 10 residents, staff, and visitors.  Findings include:  Based on observations with the Maintenance Supervisor at 2:04 p.m. on 06/16/25, the electric oven in the Activity Room/Dining room at the end of the 300 Hall had electric power and was left powered on when unattended. Based on interview at 2:04 p.m. on 06/16/25, the  Maintenance Supervisor agreed the oven was unattended and shut electrical power off to the oven.  These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.  3.1-19(b)		IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities wi audit all fire doors and resider doors to ensure they latch. CarDon Corporate facilities will audit all cooking equipment that are accessible to resident ensure they are off when unattended.	nt ties nt
SS=E	NFPA 101 Means of Egress - General			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

 $KQGJ21 \hspace{0.5cm} \textit{Facility ID:} \hspace{0.5cm} 000422$ 

If continuation sheet

Page 4 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MU		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			ETED
		155691	B. WI	. WING 06/16/2			2025
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			l	VASHINGTON ST		
MODDIE.	TOWN MANOR				STOWN, IN 46161		
WORKIS	TOWN WANCK			WORKI	310001, 110 40 10 1		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
Bldg. 01							
	<ol> <li>Based on observa</li> </ol>	tion and interview, the facility	K 0	211	K 211		07/21/2025
	failed to ensure 5 of	11 means of egress were					
	continuously mainta	nined free of all obstructions			I. The corrective actions to b	е	
	or impediments to f	ull instant use in the case of			accomplished for those		
	fire or other emerge	ncy. This deficient practice			residents found to have beer	ı	
	could affect over 20	residents, staff and visitors if			affected by the deficient		
	needing to exit the f	acility.			practice.		
					Observation 1- The community	y	
	Findings include:				failed to ensure that the path of	of	
					egress near the 400 Hall exit of	loor	
	Based on observation	ons with the Maintenance			was clear. The Maintenance		
	Supervisor during the initial walk through of the			Supervisor has relocated those		е	
	facility at 9:18 a.m. on 06/16/25, two upholstered				items. See attached picture		
	chairs and a table w	ere stored in the path of			showing the clear path of egre	showing the clear path of egress.	
	egress near the exit	door of the 400 Hall to the					
	adjoining breezeway	y outside resident sleeping			Observation 2- The community	y	
	Room 413. Based of	on observations with the		failed to ensure that the path of		of	
	Maintenance Superv	visor at 1:36 p.m. on 06/16/25,			egress near resident room 80°	1	
	the upholstered chair	rs and the table were still			was clear. The Maintenance		
	stored in the path of	egress near the exit door of			Supervisor has relocated those	е	
	the 400 Hall to the a	ndjoining breezway outside			items. See attached picture		
	resident sleeping Ro	oom 413 which limited the path			showing the clear path of egre	SS.	
	of egress in the corr	idor to six feet wide. Neither					
	the chairs nor the tal	ble was affixed to the floor or			Observation 3- The community	y	
	to the wall. Based of	on observations with the			failed to ensure that the path of	of	
	Maintenance Superv	visor at 1:24 p.m. on 06/16/25,			egress around the Cypress Rเ	ın	
	a wooden box for re	ecyclable materials, a crash cart			nurse station was clear. The		
	and a wheelchair we	ere stored in the corridor			Maintenance Supervisor has		
	opposite an upholste	ered reclining chair which was			relocated those items. See		
	not affixed to the flo	oor or to the wall near the			attached picture showing the o	lear	
	Cypress Run nurse's	s station which limited the			path of egress.		
		corridor to four feet wide.			Observation 4- The community	y	
	Based on observation	ons with the Maintenance			failed to ensure that the path of	of	
	Supervisor at 1:28 p	o.m. on 06/16/25, two beds, a			egress around the Morristown		
	•	d a table were stored in the			Manor nurse station was clear	•	
	breezeway outside t	he 800 Hall near Room 801.			The Maintenance Supervisor h	nas	
		ons with the Maintenance			relocated those items. See		
	Supervisor at 1:45 p	o.m. on 06/16/25, a wooden			attached picture showing the o	lear	
	chair was stored in t	the corridor outside the			path of egress.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 5 of 30

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155691	B. W	ING		06/16/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			VASHINGTON ST		
MODDIG	TOWN MANOR				STOWN, IN 46161		
IVIORKIS	TOWN WANDE			WORKI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Morristown Manor	nurse's station which			Observation 5- The communit	у	
	projected 24 inches	into the eight foot wide			failed to ensure that the path o	of	
	corridor. The chair	was not affixed to the floor or			egress from the memory care		
	to the wall. Based	on observations with the			courtyard to the common area	had	
	Maintenance Super	visor at 2:16 p.m. on 06/16/25,			a gate that swing in the same		
	three cardboard box	xes were stored in the corridor			direction as the path of egress	S.	
		the outside of the facility near			The Maintenance Supervisor I	has	
	resident sleeping Ro	oom 314. Based on interview			contacted K and K Fence to m	nake	
		of the observations, the			the changes.		
	Maintenance Super	_					
	aforementioned me	ans of egress was not			II. The facility will identify		
		ained free of all obstructions			other residents that may		
or impediments to full instant use in the case of				potentially be affected by the	)		
	fire or other emerge	ency.			deficient practice.		
					All staff and residents in the		
	These findings were	e reviewed with the			community have the potential	to	
	Administrator and t	he Maintenance Supervisor			be affected by this deficient		
	during the exit conf	Perence.			practice.		
	3.1-19(b)				III. The facility will put into		
					place the following systemat	ic	
	2. Based on observa	ation and interview, the facility			changes to ensure that the		
	failed to ensure 1 or	f 11 means of egress was			deficient practice does not		
	continuously maint	ained free of all obstructions			recur.		
	or impediments to f	full instant use in the case of			Observation 1,2,3,4 - The staf	f has	
	fire or other emerge	ency. LSC Section 7.2.1.4.2(2)			been in serviced that a clear		
	states side-hinged o	r pivoted-swinging type door			egress path needs to be alway	ys	
	leafs shall swing in	the direction of egress travel			maintained in the hallways. Se	ee	
		sed in an exit enclosure. This			attached in-service paperwork	ζ.	
	deficient practice co	ould affect over 10 residents,			Observation 5- The courtyard	door	
	staff and visitors if	needing to exit the facility from			has been looked at by K and h	<	
	the courtyard outsic	le the 500 Hall dining room.			Fence to have the door swing		
					changed. We are currently		
	Findings include:				waiting on their proposal to ma	ake	
	Dagad or -1	ong with the Mainter			the repair.		
		ons with the Maintenance			N/ The feelite		
		o.m. on 06/16/25, the exit door			IV The facility will monitor		
		ng room was marked as a			the corrective action by		
	<u> </u>	exit sign. The discharge for			implementing the following		
1	r ine Mill Hall dining	room evit is into an enclosed			moseuroe		1

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155691	(X2) MULTIPLE C A. BUILDING B. WING	O1	(X3) DATE SURVEY COMPLETED 06/16/2025
	PROVIDER OR SUPPLIER		868 S	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST RISTOWN, IN 46161	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	BATE
K 0324 SS=E Bldg. 01	courtyard with one the courtyard fence public way. The sin fence does not swin travel. Based on into 06/16/25, the Maint aforementioned mecontinually maintain impediments to full or other emergency.  These findings were Administrator and the during the exit confidence of the cooking Facilities.  Based on observation failed to install kitch filters in accordance states commercial constalled in accordance for Ventilation Confidence.	swinging single leaf gate in serving as the exit to the agle leaf gate in the courtyard g in the direction of egress terview at 3:19 p.m. on enance Supervisor agreed the ans of egress was not ned free of all obstructions or instant use in the case of fire erviewed with the he Maintenance Supervisor terence.  The mand interview, the facility then range hood system grease with NFPA 96. LSC 9.2.3 tooking equipment shall be not with NFPA 96, Standard trol and Fire Protection of	K 0324	CarDon Corporate facilities will audit all hallways during their annual Corporate Quality Revito ensure all exit pathways are clear.  K 324  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient	07/21/2025 De
	edition, Section 6.2 be installed at an an from the horizontal filters that require a grease shall be clear shall be constructed installed in the wron	ng Operations. NFPA 96, 2011 3.5 states grease filters shall gle not less than 45 degrees Section 6.2.5 states grease specific orientation to drain rly so designated, or the hood so that filters cannot be ng direction. This deficient t over 2 kitchen staff		practice.  Observation – The community failed to ensure that the kitche hood filters were installed in the correct direction. The Maintens Supervisor has reworked the filters, so they are installed correctly.	n ne ance
	Findings include:			II. The facility will identify other residents that may potentially be affected by the	
		ons with the Maintenance o.m. on 06/16/25, four of six		deficient practice.  All kitchen staff have the poter	ntial

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 7 of 30

			I		T			
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u>			COMPLETED	
		155691	B. WI	NG	·	06/16/	/2025	
			—	CTD DEC	ADDRESS CITY STATE TIP COT	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
MODDIA	TO 14/11 14/11/05				VASHINGTON ST			
MORRIS	TOWN MANOR			MORRI	STOWN, IN 46161			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	ATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE	
		installed horizontally in the			to be affected by this deficien	<u> </u>		
	~	system. Based on interview at			practice.			
	_	/25, the Maintenance Supervisor			'			
	_	six grease filters in the kitchen			III. The facility will put into			
	1 -	were not oriented correctly to			place the following systema	tic		
	drain grease.				changes to ensure that the			
	6- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2- 2-				deficient practice does not			
	These findings wer	re reviewed with the			recur.			
	_	the Maintenance Supervisor			The Maintenance Supervisor	has		
	during the exit con	_			been reeducated on the prope			
					way the kitchen hood filters no			
	3.1-19(b)				to be installed. A new TELS			
	3.1 19(0)				has been created to inspect the			
					kitchen hood filters. See attac			
					TELS task labeled "Morristow			
					Kitchen Hood Filter Inspection			
					TELS Task."	1		
					ILLU I ask.			
					IV The facility will monitor			
					the corrective action by			
					implementing the following			
					measures.			
					CarDon Corporate facilities w	ill		
					inspect the kitchen hood syste			
					1 .	5111		
					during their annual site visits.			
K 0351	NFPA 101							
SS=E	Sprinkler System	- Installation						
Bldg. 01	Opinikiei System	- mstallation						
Diag. 01	Based on observati	on and interview, the facility	K 03	251	K 351		07/21/2025	
		spray pattern for sprinkler	K 0.3	551	K 331		07/21/2025	
		tructed in 1 of over 50 rooms			I. The corrective actions to	ho		
						n <del>e</del>		
		LSC 19.3.5.1. NFPA 13, 2010			accomplished for those	_		
		5.5.1 states sprinklers shall be			residents found to have bee	11		
					affected by the deficient			
	_	d in Section 8.5.5.2 and Section			practice.			
		al sprinklers shall be provided to			Observation – The community			
	ensure adequate co	verage of the hazard. Sections			failed to ensure that nothing v	/as		

07/09/2025 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/16/2025 155691 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 868 S WASHINGTON ST MORRISTOWN MANOR MORRISTOWN, IN 46161 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 8.5.5.2 and 8.5.5.3 do not permit continuous or stored within 18" of the ceiling in noncontinuous obstructions less than or equal to the storage room. The 18 inches below the sprinkler deflector or in a Maintenance Supervisor has horizontal plane more than 18 inches below the removed the items and educated sprinkler deflector that prevent the spray pattern the staff that nothing can be from fully developing. This deficient practice installed withing 18" of the ceiling. could affect over ten residents, staff and visitors in the vicinity of the Morristown Manor nurse's II. The facility will identify other residents that may station. potentially be affected by the Findings include: deficient practice. All staff and residents in the Based on observations with the Maintenance community have the potential to Supervisor at 1:53 p.m. on 06/16/25, shelf storage be affected by this deficient of packaged diapers was within twelve inches of practice. the ceiling in the Storage Room by the Nutrition Pantry by the Morristown Manor nurse's station III. The facility will put into which would obstruct the sprinkler spray pattern place the following systematic of the ceiling mounted sprinklers in the room. changes to ensure that the Based on interview at 1:53 p.m. on 06/16/25, the deficient practice does not Maintenance Supervisor agreed shelf storage in recur. the room would obstruct the sprinkler coverage The Maintenance Supervisor has for the room. been reeducated on the 18" clearance needed from the These findings were reviewed with the ceilings at all times. A new TELS Administrator and the Maintenance Supervisor Task has been created to inspect during the exit conference. all storage rooms to ensure they meet all codes. See attached 3.1-19(b)TELS task labeled "Morristown Storage Room Inspection TELS Task." IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate facilities will

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21

Facility ID: 000422

If continuation sheet

inspect all storage areas during their annual Corporate Quality Review to ensure that there is

Page 9 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		l í	JILDING	onstruction 01	(X3) DATE SURVEY  COMPLETED  06/16/2025	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 868 S WASHINGTON ST MORRISTOWN, IN 46161		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
					nothing stored within 18" of the ceilings.	е
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extir					
	failed to ensure 1 of was given maintena one year apart. NFI Portable Fire Exting requires that fire exto maintenance at ir year, at the time of specifically indicate electronic notificative extinguisher mainte examination of the intended to give ma extinguisher will op and to determine if will prevent its oper replacement is nece testing or internal m Section 7.3.3 states have a tag or label s indicates the month performed, identifies work, and identifies performing the work affect over 10 reside.  Based on observation Supervisor at 4:04 per section 2 per section 2 per section 3 per section 3 per section 4 per section 3 per section 3 per section 3 per section 4 per section 3 per	ation and interview, the facility is 53 portable fire extinguishers are at periods not more than PA 10, the Standard for guishers, at Section 7.3.1.1.1 tinguishers shall be subjected attervals of not more than 1 thydrostatic test, or when ad by an inspection or on. Section 3.3.15 defines nance as a thorough fire extinguisher that is eximum assurance that a fire perate effectively and safely physical damage or condition ration, if any repair or ssary, and if hydrostatic naintenance is required. The each fire extinguisher shall necurely attached that and year the maintenance was as the person performing the attendance of the agency k. This deficient practice could nents, staff and visitors.	K 0.	355	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to ensure that all the fire extinguishers were signed off monthly and that they had affix tags showing their last annual inspection. The Maintenance Supervisor has contacted Safecare to have the proper tare installed on some fire extinguishers. The Maintenance Supervisor has been re-education the monthly inspection of a fire extinguishers.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  All staff and residents in the community have the potential be affected by this deficient practice.  III. The facility will put into	on xed ags ace ated II
	installed in the pant	ry for the Cypress Run dining locumentation indicating when			place the following systemat	ic

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 10 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED	
		155691	B. W	ING		06/16/2025	
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIER	8			VASHINGTON ST		
MORRIS	TOWN MANOR				STOWN, IN 46161		
						<u> </u>	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	T
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
		ual maintenance was			deficient practice does not		
	•	on interview at 4:04 p.m. on			recur.		
		tenance Supervisor stated a			There is a current monthly TE		
		emoved the inspection			task for this community to insp		
		maintenance tag and agreed			all fire extinguishers monthly.	See	
		ual maintenance performed for			attached TELS task labeled		
		portable fire extinguisher was			"Morristown Fire Extinguisher		
	not documented.				TELS Task"		
	These findings were	e reviewed with the			IV The facility will monitor		
		he Maintenance Supervisor			the corrective action by		
	during the exit conf	Perence.			implementing the following		
					measures.		
	3.1-19(b)				CarDon Corporate facilities wi	II	
					inspect all fire extinguishers d	uring	
		ation and interview, the facility			their annual Corporate Quality	'	
		f 53 portable fire extinguishers			Review to ensure that all fire		
	_	east monthly and the			extinguishers are signed off		
	-	ocumented including the date			monthly.		
	_	erson performing the					
	-	dance with NFPA 10. LSC					
	_	ble fire extinguishers shall be					
	· · · · · · · · · · · · · · · · · · ·	inspected and maintained in					
		FPA 10. NFPA 10, the					
		le Fire Extinguishers, 2010					
		2.1.2 states fire extinguishers					
	-	ither manually or by means of					
		oring device/system at a					
		v intervals. Where monthly					
	_	are conducted, the date the					
	_	was performed and the initials					
		rming the inspection shall be					
		nanual inspections are					
		for manual inspections shall					
		label attached to the fire					
		inspection checklist					
		or by an electronic method.					
	· ·	pt to demonstrate that at least					
	_	inspections have been					
	performed. This de	ficient practice could affect					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 11 of 30

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155691		JILDING	nstruction <u>01</u>	(X3) DATE COMPL 06/16	ETED
	PROVIDER OR SUPPLIER	₹	•	868 S W	DDRESS, CITY, STATE, ZIP COD /ASHINGTON ST STOWN, IN 46161		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
TAG	over 10 residents, s			IAG			DAIL
	Findings include:						
	Supervisor at 3:28 pmounted ABC type installed in the corr Room 510 had miss documentation on to maintenance tag for 2025. The portable contractor had affix extinguisher stating maintenance was possible and a second of the contractor at 3:51 pmounted ABC type installed in the Train had missing month on the contractor at one month period of extinguisher inspect hanging tag to the form most recent annual October 2024. Bas at 3:51 p.m. on 06/Supervisor stated at extinguisher inspect available for review aforementioned por locations had missing documentation for These findings were	rtable fire extinguisher ng monthly inspection May 2025. e reviewed with the the Maintenance Supervisor					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 12 of 30

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155691  STREET ADDRESS, CITY, STATE, ZIP COD	COMPLETED 06/16/2025
STREET ADDRESS, CITY, STATE, ZIP COD	06/16/2025
STREET ADDRESS, CITY, STATE, ZIP COD	00, 10, 2020
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER	
868 S WASHINGTON ST	
MORRISTOWN MANOR MORRISTOWN, IN 46161	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	E COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY)	DATE
K 0363 NFPA 101	
SS=E Corridor - Doors	
Bldg. 01	
Based on observation and interview, the facility K 0363 K 363	07/21/2025
failed to ensure 3 of over 50 corridor doors had no	0772172020
impediment to closing and latching into the door  I. The corrective actions to be	e
frame and would resist the passage of smoke.  accomplished for those	
This deficient practice could affect over 20 residents found to have been	
residents, staff and visitors.  affected by the deficient	
practice.	
Findings include:  Observation 1– The Community	
failed to ensure that Spa door a	-
Based on observations with the Maintenance the office door by the Cypress F	
Supervisor at 1:00 p.m. on 06/16/25, the corridor  Nurse Station to the corridor wo	
	Duid
door to the Spa by the Cypress Run nurse's shut and latch properly. The	
station was propped in the fully open position  Maintenance Supervisor remove	l l
with a folded piece of paper placed on the floor the items propping the doors op	•
under the door. The Spa was being used as a so they shut and latch properly.	l l
storage area for wheelchairs. Based on  Observation 2- The community	l l
observations with the Maintenance Supervisor at failed to ensure that the doorwa	-
1:00 p.m. on 06/16/25, the corridor door to the	
Administrative office by the Cypress Run nurse's therapy gym had compliant and	d
station was also propped in the fully open latching door hardware. The	
position with a wedge placed on the floor under  Maintenance Supervisor has	
the door. Based on observations at 3:55 p.m. on secured the secondary leaf of the	he
06/16/25, the inactive leaf in the corridor door set door so it will not open.	
to the Administrative office by the Therapy Room	
in Cypress Run was not equipped with a positive	
latching mechanism to latch the door into the door	
frame when tested to close multiple times. The other residents that may	
inactive leaf in the door set was open and not potentially be affected by the	
secured at the time of the observations. The deficient practice.	
inactive leaf was equipped with a lever inside the All staff and residents have the	
side of the door at the meeting edges of the door potential to be affected by this	
set. The lever had to be manually flipped in order deficient practice.	
to latch the door into the door frame. The active	
leaf in the door set was equipped with a positive III. The facility will put into	
latching device but would only latch into the place the following systematic	С
inactive leaf if the inactive leaf was latched into changes to ensure that the	
the door frame. Based on interview at the time of deficient practice does not	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 13 of 30

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155691	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(x3) date survey completed 06/16/2025
	PROVIDER OR SUPPLIER		868 S	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ISTOWN, IN 46161	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Supervisor agreed to corridor door location closing and latching.  These findings were	he Maintenance Supervisor		recur. Observation 1 and 2- There is TELS task to inspect all corridors every month to ensure the they close and latch properly. See attached TELS task labele "Morristown Door Inspection TELS Task"  IV The facility will monitor the corrective action by	or hat
				implementing the following measures. CarDon Corporate facilities wil inspect these areas during the annual Corporate Quality Revi to ensure all doors in the community shut and latch properly.	ir
K 0511 SS=E Bldg. 01	failed to ensure 1 of Hall corridor was so personnel. NFPA 7 Energized parts of senclosed as specific specified in 230.62((A) Enclosed. Energiso that they will not contact or shall be set (B) Guarded. Energishall be installed on control board and g	on and interview, the facility of 1 electrical panels in the 700 ecured from non-authorized 0, 2011 edition states 230.62 ervice equipment shall be d in 230.62(A) or guarded as	K 0511	K 511  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation 1– The Communificated to ensure that the electric panel near resident room 701 properly locked from unauthorientry. The Maintenance Supervisor has secured the electrical panel	ty cal was

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		A. BUILDING <u>01</u> COMPLET		(X3) DATE SURVEY COMPLETED 06/16/2025	
	ROVIDER OR SUPPLIER		868 S \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ISTOWN, IN 46161	
(X4) ID PREFIX TAG	guarded as provided means for locking of access to energized. This deficient pract residents, staff and a Findings include:  Based on observation Supervisor at 1:15 producted electrical president sleeping Rollocked or otherwise personnel. Based on 06/16/25, the Maint wall mounted electroutside resident sleeping was not locked or onon-authorized personnel. These findings were	e reviewed with the he Maintenance Supervisor	ID PREFIX TAG	III. The facility will identify other residents that may potentially be affected by the deficient practice.  All staff and residents on the Hall have the potential to be affected by this deficient practice.  III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.  Observation 1- There is a new weekly TELS task to inspect a electrical panels in the commercians to ensure they are locked See attached TELS task label "Morristown Electrical Panel Locking TELS Task"  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities we inspect all electrical panels dutheir annual Corporate Quality Review to ensure they are locked.	pate  Pate
K 0522 SS=E Bldg. 01		ng Device on and interview, the facility 1 maintenance office fuel-fired	K 0522	K 522	07/21/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155691	B. W	ING		06/16/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8	868 S WASHINGTON ST				
MORRIS'	TOWN MANOR		MORRISTOWN, IN 46161				
ı			1		, - · <del>-</del> ·	1	are:
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		n accordance with LSC	+	TAG			DATE
	•	.2.2(1) states any heating device			I. The corrective actions to be	e	
		heating plant shall have			accomplished for those residents found to have beer	,	
		nmediately stop the flow of			affected by the deficient	'	
	-	the equipment in case of			practice.		
		nperature or ignition failure.			Observation – The community		
		ice could affect over 50			failed to ensure that the gas fir		
	_	visitors in Morristown Manor.			hanging heater had an emerge		
	•				shut off right inside the door to	-	
	Findings include:				room. The Maintenance Supe		
					is having an electrician put a s	top	
	Based on observations with the Maintenance				switch on the power supply that	at	
	Supervisor at 3:02 p.m. on 06/16/25, the				feeds this unit.		
		iling mounted suspended					
		enance office in Morristown			II. The facility will identify		
	_	ipped with a safety feature to			other residents that may		
		e flow of fuel and shut down			potentially be affected by the	•	
		se of either excessive			deficient practice.		
		tion failure. The maintenance			All staff and residents in the		
		location for the dry sprinkler			community have the potential	to	
	•	rristown Manor and the as most likely in place to			be affected by this deficient		
	-	ation was maintained above 40			practice.		
		at all times. Based on			III. The facility will put into		
	interview at 3:02 p.:				place the following systemat	ic	
		visor agreed the natural-gas			changes to ensure that the	.	
	_	ed suspended heater was not			deficient practice does not		
	_	ety feature to immediately stop			recur.		
		shut down the equipment in			This is a permanent fix, and no		
		sive temperature or ignition			further follow-up is needed.		
	failure.						
					IV The facility will monitor		
	_	viewed with the Administrator			the corrective action by		
		e Supervisor at the exit			implementing the following		
	conference.				measures.		
	2.1.10(1)				This is a permanent fix, and no	)	
	3.1-19(b)				further follow-up is needed.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KQGJ21 Facility ID: 000422

If continuation sheet Page 16 of 30

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING 01 COMPL  B. WING 06/16/			ETED		
	PROVIDER OR SUPPLIER			868 S W	DDRESS, CITY, STATE, ZIP COD /ASHINGTON ST STOWN, IN 46161		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION
TAG K 0711	NFPA 101	LSC IDENTIFYING INFORMATION		TAG	DLI CILACI I		DATE
SS=C Bldg. 01	Evacuation and R	elocation Plan					
		riew and interview, the facility written plan that addressed all	K 07	11	K 711		07/21/2025
	19.7.2.2 requires a v fire safety plan that following: (1) Use of alarms (2) Transmission of (3) Emergency phot (4) Response to alat (5) Isolation of fire (6) Evacuation of in (7) Evacuation of st (8) Preparation of flevacuation (9) Extinguishment	nmediate area noke compartment oors and building for			I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to ensure that the fire we and smoke barrier map and locations were in the Emerger Disaster Preparedness Binder review. The Maintenance Supervisor has placed the mathe binders.  II. The facility will identify other residents that may potentially be affected by the	n all ncy for p in	
	Based on review of Procedures" section Preparedness" docu	the "Fire Policies and of "Emergency Disaster mentation dated 12/06/24 with			deficient practice. All staff and residents in the community have the potential be affected by this deficient practice.	to	
	06/16/25, the writted did not address the smoke barrier doors documentation state but no map or fire zincluded in the 12/0 documentation to ac smoke compartmen p.m. on 06/16/25, the agreed the written for the smoke written for the smoke compartmen p.m. on 06/16/25, the agreed the written for the smoke with the smoke compartmen p.m. on 06/16/25, the smoke written for the smoke barrier doors documentation states and the smoke barrier doors documentation to accompanie with the smoke written for the sm	pervisor at 12:00 p.m. on In fire safety plan for the facility location of fire barrier doors or In the facility. The fire plan In the facility. The fire plan In the facility one documentation was In the facility of the fire plan In the facility of the facility In the facility of the facility In the f			III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  The Maintenance Supervisor I been reeducated on the fire ba and smoke door map to ensur knows all of there locations.	has arrier	
	smoke barrier doors	location of fire barrier doors or in the facility.			IV The facility will monitor the corrective action by		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 17 of 30

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01			(X3) DATE SURVEY COMPLETED	
		155691	B. W	ING		06/16/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 868 S WASHINGTON ST MORRISTOWN, IN 46161				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIO DATE	ON
	These findings were	e reviewed with the he Maintenance Supervisor			implementing the following measures. CarDon Corporate facilities wi inspect the Emergency Preparedness and Life Safety Binder to ensure the fire barrie and smoke door map is currer and in place.	II er	
K 0712 SS=C Bldg. 01	failed to conduct que times under varying for three of four cale practice could affect visitors in the facility. Findings include:  Based on review of Documentation "Fir Supervisor at 12:00 third shift fire drills unexpected times up three of four calendary for third shift fire dried to the four calendary for the Maintenance Supervisor in the Supervisor in the facility of the	Direct Supply TELs Logbook to Drills" with the Maintenance p.m. on 06/16/25, three of four were not conducted at der varying conditions for ar quarters. Documentation rills conducted within the most in period on 06/22/24, 12/23/24 ted the fire drill was conducted 37 p.m., 11:30 p.m. and 11:00 review at 12:00 p.m. on 06/16/25, pervisor stated the facility of shifts per day but he for three shifts, additional third	K 0	712	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to ensure that the 3rd shifter drills had varying condition and times. The Maintenance Supervisor has been re-educa on Fire Drills and to make sure they have varying conditions at times.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  All staff and residents in the community have the potential be affected by this deficient	nift nift nis nted e nnd	25

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

PRINTED: 07/09/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  01	(X3) DATE SURVEY COMPLETED 06/16/2025	
	PROVIDER OR SUPPLIER		868 S	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ISTOWN, IN 46161	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	recent twelve month review and agreed the fire drills were not of under varying cond These findings were	e reviewed with the he Maintenance Director		practice.  III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.  The Maintenance Supervisor here Drills to make sure they have varying conditions and times.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities will review the communities fire dril activation paperwork during the annual Corporate Quality Reviet to ensure that they are at varying times.	as and 3 I eir ew
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulati	ons			
-	failed to ensure smo into ashtrays and m self-closing cover d can be emptied of n safe design in 1 of 1	on and interview, the facility oking materials were deposited etal containers with evices into which ashtrays oncombustible material and outdoor areas where smoking this deficient practice could	K 0741	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to ensure that there was appropriate metal container to	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet

Page 19 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155691	B. W	ING		06/16	/2025
		<u> </u>	<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				VASHINGTON ST		
MODDIe.							
IVIORKIS	TOWN MANOR			MORRISTOWN, IN 46161			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD E		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	·-	DATE
					dispose of cigarette butts in ne	ear	
	Based on observations with the Maintenance				the employee smoking area. T		
		o.m. on 06/16/25, an open top			Maintenance Supervisor has		
	-	ved as the repository for			purchased a new metal trash	can	
	-	e outdoor smoking area for			and self-closing lid.		
	-	he employee breakroom.			]		
		at 2:48 p.m. on 06/16/25, the			II. The facility will identify		
		visor stated the area was a			other residents that may		
	-	and agreed a metal container			potentially be affected by the	)	
	-	ver devices was not provided			deficient practice.	-	
	_	ion where smoking was taking			All staff and residents in the		
	place.				community have the potential	to	
	Piace				be affected by this deficient		
	These findings were	reviewed with the			practice.		
		he Maintenance Supervisor			practice.		
	during the exit conf	_			III. The facility will put into		
	during the exit com	cronec.			place the following systemat	ic	
	3.1-19(b)				changes to ensure that the	iic	
	3.1-17(0)				deficient practice does not		
					recur.		
					The Maintenance Supervisor I	200	
					been reeducated on what	ias	
						adad	
					appropriate containers are neg		
					to properly dispose of cigarette	e	
					butts.		
					IV The facility will marries		
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
					CarDon Corporate facilities wi		
					inspect the smoking area duri		
					their annual Corporate Quality	,	
					Review.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet

Page 20 of 30

07/09/2025 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 06/16/2025 155691 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 868 S WASHINGTON ST MORRISTOWN MANOR MORRISTOWN, IN 46161 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0918 SS=C Electrical Systems - Essential Electric Syste Bldg. 01 Based on record review and interview, the facility K 0918 K 918 07/21/2025 failed to document a complete written record of monthly generator load testing for 1 month of the I. The corrective actions to be most recent 12 month period in accordance with accomplished for those NFPA 110, Standard for Emergency and Standby residents found to have been Power Systems. NFPA 110, 2010 Edition, Section affected by the deficient 8.4.1 states Emergency Power Supply Systems practice. (EPSS), including all appurtenant components Observation – The community shall be inspected weekly and exercised under failed to ensure that the 2 different load at least monthly. Section 8.4.2.4 states generators at the community were spark-ignited generator sets shall be exercised at maintained per NFPA standards. least once a month with the available EPSS load The Maintenance Supervisor has for 30 minutes or until the water temperature and been re educated on the proper the oil pressure have stabilized. NFPA 99, 2012 generator run times and the Edition, Section 6.4.4.2 requires a written record of documentation needed. inspection, performance, exercising period, and repairs for the generator to be regularly II. The facility will identify maintained and available for inspection by the other residents that may authority having jurisdiction. This deficient potentially be affected by the practice could affect all residents, staff and deficient practice. visitors. All staff and residents in the community have the potential to Findings include: be affected by this deficient practice. Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: III. The facility will put into Test Generator Under Load" documentation with place the following systematic the Maintenance Supervisor at 12:00 p.m. on changes to ensure that the 06/16/25, weekly load testing documentation for deficient practice does not December 2024 listed the "Run time" as "20" recur. minutes. Based on interview at 12:00 p.m. on The Maintenance Supervisor has 06/16/25, the Maintenance Supervisor stated the been re educated on the proper facility has two separate emergency generators generator run times and the which are each LP gas-fuel fired, the facility documentation needed. conducts and documents weekly load testing for each generator, additional load testing IV The facility will monitor documentation for December 2024 was not the corrective action by

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21

Facility ID: 000422

If continuation sheet

Page 21 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED B. WING 06/16/2025				
		155691	B. W	ING		06/16/2	2025
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 868 S WASHINGTON ST MORRISTOWN, IN 46161				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documentation for g December 2024 was of 30 minutes.	he Maintenance Supervisor			implementing the following measures. CarDon Corporate facilities wi inspect all generator paperword during their annual Corporate Quality Review to ensure that there are being maintained correctly.	rk	
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure 2 of power strips were not fixed wiring in 1 of basement. LSC 19.  with Section 9.1. Lowiring and equipment National Electrical of Article 400.8 requires permitted, flexible of used as a substitute LSC Section 4.5.7 sequipment or safegutes shall be designed, in accordance with all This deficient practice residents, staff and Findings include:  Based on observation Supervisor at 3:35 pand a microwave over strip in the MDS Rose	ent - Power Cords and on and interview, the facility of 2 extension cords including ot used as a substitute for 1 equipment rooms in the 5.1 requires utilities to comply SC 9.1.2 requires electrical ent to comply with NFPA 70, Code, 2011 Edition. NFPA 70, es that, unless specifically cords and cables shall not be for fixed wiring of a structure. etates any building service hard provided for life safety installed and approved in applicable NFPA standards. icic could affect over 5 evisitors in the facility.  ons with the Maintenance on. on 06/16/25, a coffee pot even were plugged into a power oom. Based on observations ce Supervisor at 3:59 p.m. on	K 0	920	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to ensure that the there no appliances plugged into postrips within the community. The Maintenance Supervisor has removed the power strip from MDS and Admin office.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  All staff and residents in the community have the potential be affected by this deficient practice.  III. The facility will put into	were wer he the	07/21/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet

Page 22 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		01	COMPL	
		155691	B. WING			06/16/	2025
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
MORRIS <sup>*</sup>	TOWN MANOR				/ASHINGTON ST STOWN, IN 46161		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	]	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
	-	ot was plugged into a power L 1363A in the Cypress Run			place the following systemat changes to ensure that the	IC	
	Administrative Office by the fireplace. Based on				deficient practice does not		
		m. and at 3:59 p.m. on 06/16/25,			recur.		
	_	pervisor agreed power strips			The Maintenance Supervisor h	nas	
	_	a substitute for fixed wiring at			been re educated on when an	d	
	the aforementioned	locations.			where power strips are able to		
	Those for 11	a marriante ad resista sta a			used within the community. The		
	These findings were	he Maintenance Supervisor			is a monthly TELS Task to instance the community to ensure there		
	during the exit conf	-			no power strips being used. S		
during the exit conference.				Attached TELS Task labeled			
	3.1-19(b)				"Morristown Power Strip Audit		
					TELS Task"		
					IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities will inspect the community during annual Corporate Quality Revito ensure that there are no postrips in use.	their ew	
K 0923	NFPA 101						
SS=D Bldg. 01		Cylinder and Container					
ום טועק. U ו	Storag  Based on observation	on and interview, the facility	K 092	<sub>3</sub>	K 923		07/21/2025
		2 storage locations of	K 092.	J	1. 020		07/21/2023
	nonflammable gase	s equal to or greater than 3000			I. The corrective actions to b	е	
		ared against unauthorized			accomplished for those		
		ealth Care Facilities Code, 2012			residents found to have been	1	
		3.2.1 states storage locations an enclosure or within an			affected by the deficient practice.		
		ace of noncombustible or			Observation – The community		
		construction, with doors (or			failed to ensure that the		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 23 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/16/2025	
	PROVIDER OR SUPPLIE	R	868 S V	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ISTOWN, IN 46161	
(X4) ID PREFIX TAG	summary (EACH DEFICIENT REGULATORY OF gates outdoors) that unauthorized entry affect over 2 staff a the oxygen storage office near the serve Findings include:  Based on observati Supervisor at 2:55 entry door to the of maintenance office equipped with an of handle to secure ag the key to unlock the handle while the re- contained five lique 'E' type cylinders. on 06/16/25, the M he did not know wh normally kept and room by the mainted corridor was not lo secure against unautor.  These findings were	cons with the Maintenance p.m. on 06/16/25, the corridor exygen storage room by the enear the service corridor was operable lock on the door gainst unauthorized entry but the door was kept in the door oom was unattended. The room id oxygen containers and one Based on interview at 2:55 p.m. faintenance Supervisor stated there the key to the room is agreed the oxygen storage enance office near the service ocked or kept by other means to athorized entry.			e to ted  gen taff ted  tic  has they m at all
				room door us shut and locked	l.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet

Page 24 of 30

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 06/16/2025			ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  868 S WASHINGTON ST  MORRISTOWN, IN 46161				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0930 SS=A Bldg. 01	Based on observation failed to protect 2 of the use of liquid oxypatient bed location 99, Health Care Fac Section 11.7.4 state liquid oxygen permipatient bed location 120 L (31.6 gallons location or patient of separated from the parriers and horizon minimum fire resist accordance with the Section 7.2.4.3.10 min horizontal exits a automatic-closing, affect over 2 resident Findings include:  Based on observation Supervisor at 9:17 at through of the facility oxygen container with Room 413. Based of Maintenance Superthe liquid oxygen corresident sleeping Roobservations with the 1:55 p.m. on 06/16/containers were stored.	Liguid Oxygen Equipment on and interview, the facility of over 50 resident rooms from orgen containers stored in a or patient care room. NFPA illities Code, 2012 Edition, of the maximum total quantity of orgen containers and in use in a or patient care room shall be of provided that the patient bed are room, or both, are remainder of the facility by fire orgen that assemblies having a ance rating of 1 hour in orgen containers and orgen to the facility by fire orgen that assemblies having a ance rating of 1 hour in orgen containers and orgen to the facility by orgen that assemblies having a ance rating of 1 hour in orgen containers and orgen to the facility by orgen that assemblies having a ance rating of 1 hour in orgen containers and orgen to the facility by orgen to the facility by orgen to the facility by orgen and orgen to the facility by orgen to the facility by orgen to the facility by orgen and orgen to the facility by orgen to th	K 09	930	I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.  Observation – The community failed to protect 2 dover 50 resident rooms from the use of liquid oxygen containers stored in a patient bed location patient care room. The reside room 413 no longer resides in community. The liquid oxygen container in 309 is medically necessary as its a tritate order that exceeds 5L's and the capabilities of a concentrator. Fi02 is higher on the liquid oxycontainer versus a concentrator. The tank in room 309 isn't use fill portable tanks.  II. The facility will identify other residents that may potentially be affected by the deficient practice.  All staff and residents in the community have the potential be affected by this deficient practice.	of the solution of the	07/21/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/16/2025	
	PROVIDER OR SUPPLIEI	3	868 S \	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ISTOWN, IN 46161	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the room. Each of rooms were not sep the facility by fire be assemblies having of 1 hour. The corn self-closing or auto door to the room we fire resistance ratin door. Based on intended and at 3:33 p.m. on Supervisor agreed be stored and in use in not maintained with rating of 1 hour.  These findings were	by one of the two residents of the two resident sleeping parated from the remainder of partiers and horizontal a minimum fire resistance rating ridor door to each room was not matic closing. Each corridor as equipped with a 20-minute g label affixed to the top of the erview at 1:55 p.m. on 06/16/25 of 06/16/25, the Maintenance in the rooms and each room was in a minimum fire resistance.		III. The facility will put into place the following systemat changes to ensure that the deficient practice does not recur.  The Maintenance Supervisor in serviced the staff to ensure are aware that liquid oxygen containers cannot be stored in resident rooms unless they at medically necessary and portables aren't being filled frothem.  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities wi inspect resident rooms during annual Corporate Quality Rev to ensure that liquid oxygen is being used.	has they re om
K 0000					
Bldg. 02	Licensure Survey v	000422 155691	K 0000	Please find enclosed the Plan Correction for the State Licens Survey conducted on June 16 2025. This letter is to inform y that the plan of correction attached is to serve as Morris' Manor'sy credible allegation o compliance. We are requestin paper compliance for this plan correction.	sure , , /ou town f

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet Page 26 of 30

PRINTED: 07/09/2025 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155691	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 06/16/2025	
	PROVIDER OR SUPPLIER	2	868 S	ADDRESS, CITY, STATE, ZIP COD WASHINGTON ST ISTOWN, IN 46161		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	Manor was found n Requirements for P Medicare/Medicaid Life Safety from Fi	Code survey, Morristown ot in compliance with articipation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ction Association (NFPA) 101,		If you have any further question please do not hesitate to contain me at 765-763-6012.  Sincerely,	·	
	Health Care Occupations one story facility constructed in 2000 addition identified a 2010. Each buildin V (111) construction facility has a fire all detection in the continuous the corridor. The farm facility has a fire all detection in the continuous continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection in the continuous facility has a fire all detection facility has a fire all detection	ity consists of Building 01 and the attached Cypress Run as Building 02 constructed in g was determined to be of Type n and fully sprinklered. The arm system with smoke ridor and in all areas open to acility has smoke detectors re alarm system installed in all oms. The facility has a had a census of 98 at the time idents have customary access The facility has three detached hich were each not		Andrew Buzzard, HFA Administrator Morristown Manor		
K 0361	NFPA 101	npleted on 06/24/25				
SS=E Bldg. 02	failed to ensure 1 of Run were separated partition capable of smoke as required i an Exception per 19	on and interview, the facility f 1 therapy rooms in Cypress from the corridor by a resisting the passage of n a sprinklered building, or met 0.3.6.1(7). LSC 19.3.6.1(7) states an patient sleeping rooms,	K 0361	K 361  I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.		

FORM CMS-2567(02-99) Previous Versions Obsolete

treatment rooms, and hazardous areas shall be

Event ID:

KQGJ21

Facility ID: 000422

Observation - The community

If continuation sheet

Page 27 of 30

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>02</u>		02	COMPLETED	
1556		155691	B. WING			06/16/2025	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					VASHINGTON ST		
MORRISTOWN MANOR					STOWN, IN 46161		
	Г		ı		, - · · · ·		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE			TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE	
		and unlimited in area,			failed to ensure that the doorw		
		pace and corridors which the the same smoke compartment		to the therapy gym from the main		iain	
		electrically supervised		corridor had compliant and			
		etection system in accordance		latching door hardware. The			
		Each space is protected by an			Maintenance Supervisor has	tho	
		s, and (c) The space does not			secured the secondary leaf of door so it will not open.	u I <del>C</del>	
	_	· · · · · · · · · · · · · · · · · · ·			uoor so it wiii not open.		
	to obstruct access to required exits. This deficient practice could affect over 5 residents, staff and				II. The facility will identify		
	1 ~				other residents that may		
	visitors in the vicinity of the Cypress Run Therapy Room.				potentially be affected by the	2	
	Therapy Room.				deficient practice.	•	
	Findings include:				All staff and residents in the		
	i mamga meraac.				community have the potential	to	
	Based on observations with the Maintenance				be affected by this deficient		
	Supervisor at 3:54 p.m. on 06/16/25, the inactive				practice.		
	leaf in the corridor door set to the Therapy Room				practice.		
		s not equipped with a positive			III. The facility will put into		
	1	to latch the door into the door			place the following systemat	ic	
	1	to close multiple times. The			changes to ensure that the		
		door set was open and not			deficient practice does not		
		of the observations. The			recur.		
	inactive leaf was eq	uipped with a lever inside the			This is a permanent resolution	ı to	
		he meeting edges of the door			the issue so there will be no fo		
set. The lever had to be manu		to be manually flipped in order			up needed.		
	to latch the door into the door frame. The active leaf in the door set was equipped with a positive latching device but would only latch into the inactive leaf if the inactive leaf was latched into the door frame. Based on interview at 3:54 p.m. on						
					IV The facility will monitor		
					the corrective action by		
					implementing the following		
					measures.		
	06/16/25, the Maintenance Supervisor agreed the				CarDon Corporate facilities wi		
	corridor door set to the aforementioned Therapy			audit all doors during their annual			
	Room was not equipped with a positive latching				Corporate Quality Review to		
	device on each door leaf to latch the door into the				ensure the therapy doors latch	1	
	door frame.				properly.		
	Those findings	a raviawad with the					
	These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155691		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  06/16/2025			
	PROVIDER OR SUPPLIER			868 S W	NDDRESS, CITY, STATE, ZIP COD VASHINGTON ST STOWN, IN 46161			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 3.1-19(b)		PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
K 0754 SS=E Bldg. 02	NFPA 101 Soiled Linen and Based on observation failed to ensure una receptacles stored in stored in a room production accordance with Sepractice could affect visitors.  Findings include: Based on observation Supervisor at 1:28 punattended trash receptacy outside to Documentation afficient at the second production afficient at 1:28 punatterview	on and interview, the facility ttended soiled linen and trash in 1 of 11 means of egress were objected as a hazardous area in ection 19.7.5.7. This deficient it over 20 residents, staff and ons with the Maintenance of the staff and one with the Maintenance of the staff and of t	K 075	4	I. The corrective actions to accomplished for those residents found to have bee affected by the deficient practice.  Observation – The community failed to ensure that the trash receptacle in the Cypress Run Hall had a lid on it. The Maintenance Supervisor has re-educated all staff that any waste receptacles or trash ca over 32 gallons needs to alway have a lid on them and stored the correct room. See attached in-service paperwork  II. The facility will identify other residents that may potentially be affected by the deficient practice.  All staff and residents in the community have the potential be affected by this deficient practice.  III. The facility will put into place the following systematchings to ensure that the deficient practice does not recur.  The Maintenance Supervisor re-educated all staff that any	n 800 ns ays lin ed	07/21/2025	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

KQGJ21 Facility ID: 000422

If continuation sheet

Page 29 of 30

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

PRINTED: 07/09/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155691	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/16/2025		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 868 S WASHINGTON ST MORRISTOWN, IN 46161				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CC	(X5) OMPLETION DATE	
				waste receptacles or trash car over 32 gallons needs to alwa have a lid on them and stored the correct room. See attache in-service paperwork  IV The facility will monitor the corrective action by implementing the following measures.  CarDon Corporate facilities wi inspect all trash receptacles during their annual Corporate Quality Review to ensure they have lids on them and stored the proper locations.	ys in ed		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: KQGJ21 Facility ID: 000422 If continuation sheet Page 30 of 30