STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING -- B. WING	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORRISTOWN MANOR	868 S WASHINGTON ST MORRISTOWN, IN 46161

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/16/25 Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030 At this Emergency Preparedness survey, Morristown Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 119 certified beds. At the time of the survey, the census was 98. Quality Review completed on 06/24/25	E 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on June 16, 2025. This letter is to inform you that the plan of correction attached is to serve as Morristown Manor'sy credible allegation of compliance. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-763-6012. Sincerely, Andrew Buzzard, HFA Administrator Morristown Manor	
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: 06/16/25 Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030	K 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on June 16, 2025. This letter is to inform you that the plan of correction attached is to serve as Morristown Manor'sy credible allegation of compliance. We are requesting paper compliance for this plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Buzzard	Administrator	07/07/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	At this Life Safety Code survey, Morristown Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility consists of Building 01 constructed in 2000 and the attached Cypress Run addition identified as Building 02 constructed in 2010. Each building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 119 and had a census of 98 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has three detached storage buildings which were each not sprinklered. Quality Review completed on 06/24/25		If you have any further questions, please do not hesitate to contact me at 765-763-6012. Sincerely, Andrew Buzzard, HFA Administrator Morristown Manor	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other 1. Based on observation and interview, the facility failed to maintain latching hardware on 2 of over 8 cross corridor door sets and on 1 of 1 Main Dining Rooms per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents. staff and visitors.	K 0100	**K 100** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community	07/21/2025

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	Findings include: Based on observations with the Maintenance Supervisor at 12:58 p.m. on 06/16/25, each door in the cross corridor door set by the Cypress Run conference room was equipped with latching hardware to latch each door into the door frame but the door set failed to latch into the door frame when tested to close multiple times. Each door in the door set was also equipped with a wall mounted magnetic holding device set to release the door to close with fire alarm system activation. Based on observations with the Maintenance Supervisor at 1:02 p.m. on 06/16/25, each door in the cross corridor door set by Room 601 was equipped with latching hardware to latch each door into the door frame but the door set failed to latch into the door frame when tested to close multiple times. Each door in the door set was also equipped with a wall mounted magnetic holding device set to release the door to close with fire alarm system activation. Based on observations with the Maintenance Supervisor at 2:28 p.m. on 06/16/25, the corridor door set serving as the entrance to the Main Dining room by the main entrance lobby was also equipped with latching hardware to latch each door into the door frame but each door failed to latch into the door frame when tested to close multiple times. Based on interview at the time of each of the observations, the Maintenance Supervisor agreed each of the three door set's latching hardware failed to latch each door into the door frame when tested to close multiple times. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		failed to ensure that the 3 different fire door sets positively latched into the door frame. The Maintenance Supervisor has repaired all door sets so they latch. Observation 2- The community failed to ensure that the oven in the south dining room was turned off when unattended. The Maintenance Supervisor shut the oven off immediately. **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 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 current weekly TELS task to inspect all fire doors and resident doors to ensure they latch. See attached TELS task labeled “Morristown Door Inspection TELS Task” Observation 2- The community held an in-service to educate staff that all ovens and cooking appliances that are accessible to residents must be shut off when not in use. See attached in-service paperwork.	

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	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 will audit all fire doors and resident doors to ensure they latch. CarDon Corporate facilities will audit all cooking equipment that are accessible to residents to ensure they are off when unattended.	
K 0211 SS=E	NFPA 101 Means of Egress - General			

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Bldg. 01	1. Based on observation and interview, the facility failed to ensure 5 of 11 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Supervisor during the initial walk through of the facility at 9:18 a.m. on 06/16/25, two upholstered chairs and a table were stored in the path of egress near the exit door of the 400 Hall to the adjoining breezeway outside resident sleeping Room 413. Based on observations with the Maintenance Supervisor at 1:36 p.m. on 06/16/25, the upholstered chairs and the table were still stored in the path of egress near the exit door of the 400 Hall to the adjoining breezway outside resident sleeping Room 413 which limited the path of egress in the corridor to six feet wide. Neither the chairs nor the table was affixed to the floor or to the wall. Based on observations with the Maintenance Supervisor at 1:24 p.m. on 06/16/25, a wooden box for recyclable materials, a crash cart and a wheelchair were stored in the corridor opposite an upholstered reclining chair which was not affixed to the floor or to the wall near the Cypress Run nurse's station which limited the path of egress in the corridor to four feet wide. Based on observations with the Maintenance Supervisor at 1:28 p.m. on 06/16/25, two beds, a mattress, a chair and a table were stored in the breezeway outside the 800 Hall near Room 801. Based on observations with the Maintenance Supervisor at 1:45 p.m. on 06/16/25, a wooden chair was stored in the corridor outside the	K 0211	**K 211** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1- The community failed to ensure that the path of egress near the 400 Hall exit door was clear. The Maintenance Supervisor has relocated those items. See attached picture showing the clear path of egress. Observation 2- The community failed to ensure that the path of egress near resident room 801 was clear. The Maintenance Supervisor has relocated those items. See attached picture showing the clear path of egress. Observation 3- The community failed to ensure that the path of egress around the Cypress Run nurse station was clear. The Maintenance Supervisor has relocated those items. See attached picture showing the clear path of egress. Observation 4- The community failed to ensure that the path of egress around the Morristown Manor nurse station was clear. The Maintenance Supervisor has relocated those items. See attached picture showing the clear path of egress.	07/21/2025

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	Morristown Manor nurse's station which projected 24 inches into the eight foot wide corridor. The chair was not affixed to the floor or to the wall. Based on observations with the Maintenance Supervisor at 2:16 p.m. on 06/16/25, three cardboard boxes were stored in the corridor near the exit door to the outside of the facility near resident sleeping Room 314. Based on interview at the time of each of the observations, the Maintenance Supervisor agreed the aforementioned means of egress was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 11 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC Section 7.2.1.4.2(2) states side-hinged or pivoted-swinging type door leafs shall swing in the direction of egress travel where the door is used in an exit enclosure. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility from the courtyard outside the 500 Hall dining room. Findings include: Based on observations with the Maintenance Supervisor at 3:19 p.m. on 06/16/25, the exit door in the 500 Hall dining room was marked as a facility exit with an exit sign. The discharge for the 500 Hall dining room exit is into an enclosed		Observation 5- The community failed to ensure that the path of egress from the memory care courtyard to the common area had a gate that swing in the same direction as the path of egress. The Maintenance Supervisor has contacted K and K Fence to make the changes. **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 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 1,2,3,4 - The staff has been in serviced that a clear egress path needs to be always maintained in the hallways. See attached in-service paperwork. Observation 5- The courtyard door has been looked at by K and K Fence to have the door swing changed. We are currently waiting on their proposal to make the repair. **IV The facility will monitor the corrective action by implementing the following measures.**	

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	courtyard with one swinging single leaf gate in the courtyard fence serving as the exit to the public way. The single leaf gate in the courtyard fence does not swing in the direction of egress travel. Based on interview at 3:19 p.m. on 06/16/25, the Maintenance Supervisor agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		CarDon Corporate facilities will audit all hallways during their annual Corporate Quality Review to ensure all exit pathways are clear.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to install kitchen range hood system grease filters in accordance with NFPA 96. LSC 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.3.5 states grease filters shall be installed at an angle not less than 45 degrees from the horizontal. Section 6.2.5 states grease filters that require a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so that filters cannot be installed in the wrong direction. This deficient practice could affect over 2 kitchen staff Findings include: Based on observations with the Maintenance Supervisor at 2:35 p.m. on 06/16/25, four of six	K 0324	**K 324** **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 kitchen hood filters were installed in the correct direction. The Maintenance Supervisor has reworked the hood filters, so they are installed correctly. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All kitchen staff have the potential	07/21/2025

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	grease filters were installed horizontally in the kitchen range hood system. Based on interview at 2:35 p.m. on 06/16/25, the Maintenance Supervisor agreed four of the six grease filters in the kitchen range hood system were not oriented correctly to drain grease. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		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.** The Maintenance Supervisor has been reeducated on the proper way the kitchen hood filters need to be installed. A new TELS Task has been created to inspect the kitchen hood filters. See attached TELS task labeled "Morristown Kitchen Hood Filter Inspection TELS Task." **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect the kitchen hood system during their annual site visits.	
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 over 50 rooms 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	K 0351	**K 351** **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 nothing was	07/21/2025

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	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 over ten residents, staff and visitors in the vicinity of the Morristown Manor nurse's station. Findings include: Based on observations with the Maintenance Supervisor at 1:53 p.m. on 06/16/25, shelf storage of packaged diapers was within twelve inches of the ceiling in the Storage Room by the Nutrition Pantry by the Morristown Manor nurse's station which would obstruct the sprinkler spray pattern of the ceiling mounted sprinklers in the room. Based on interview at 1:53 p.m. on 06/16/25, the Maintenance Supervisor agreed shelf storage in the room would obstruct the sprinkler coverage for the room. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		stored within 18" of the ceiling in the storage room. The Maintenance Supervisor has removed the items and educated the staff that nothing can be installed withing 18" of the ceiling. **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 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.** The Maintenance Supervisor has been reeducated on the 18" clearance needed from the ceilings at all times. A new TELS Task has been created to inspect all storage rooms to ensure they meet all codes. See attached 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 inspect all storage areas during their annual Corporate Quality Review to ensure that there is	

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			nothing stored within 18" of the ceilings.	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers 1. Based on observation and interview, the facility failed to ensure 1 of 53 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor at 4:04 p.m. on 06/16/25, the wall mounted ABC type portable fire extinguisher installed in the pantry for the Cypress Run dining run had no affixed documentation indicating when	K 0355	**K 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 on monthly and that they had affixed tags showing their last annual inspection. The Maintenance Supervisor has contacted Safecare to have the proper tags re installed on some fire extinguishers. The Maintenance Supervisor has been re-educated on the monthly inspection of all 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 to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the**	07/21/2025

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	the most recent annual maintenance was performed. Based on interview at 4:04 p.m. on 06/16/25, the Maintenance Supervisor stated a resident probably removed the inspection contractor's annual maintenance tag and agreed the most recent annual maintenance performed for the aforementioned portable fire extinguisher was not documented. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 53 portable fire extinguishers were inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect		**deficient practice does not recur.** There is a current monthly TELS task for this community to inspect all fire extinguishers monthly. See attached TELS task labeled "Morristown Fire Extinguisher TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all fire extinguishers during their annual Corporate Quality Review to ensure that all fire extinguishers are signed off monthly.	

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	over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor at 3:28 p.m. on 06/16/25, the wall mounted ABC type portable fire extinguisher installed in the corridor outside resident sleeping Room 510 had missing monthly inspection documentation on the contractor affixed maintenance tag for the one month period of May 2025. The portable fire extinguisher inspection contractor had affixed a hanging tag to the fire extinguisher stating the most recent annual maintenance was performed in October 2024. Based on observations with the Maintenance Supervisor at 3:51 p.m. on 06/16/25, the wall mounted ABC type portable fire extinguisher installed in the Training room in Cypress Run also had missing monthly inspection documentation on the contractor affixed maintenance tag for the one month period of May 2025. The portable fire extinguisher inspection contractor had affixed a hanging tag to the fire extinguisher stating the most recent annual maintenance was performed in October 2024. Based on interview at 3:28 p.m. and at 3:51 p.m. on 06/16/25, the Maintenance Supervisor stated additional monthly fire extinguisher inspection documentation was not available for review and agreed the aforementioned portable fire extinguisher locations had missing monthly inspection documentation for May 2025. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)			

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	155691	A. BUILDING 01 B. WING	06/16/2025

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor at 1:00 p.m. on 06/16/25, the corridor door to the Spa by the Cypress Run nurse's station was propped in the fully open position with a folded piece of paper placed on the floor under the door. The Spa was being used as a storage area for wheelchairs. Based on observations with the Maintenance Supervisor at 1:00 p.m. on 06/16/25, the corridor door to the Administrative office by the Cypress Run nurse's station was also propped in the fully open position with a wedge placed on the floor under the door. Based on observations at 3:55 p.m. on 06/16/25, the inactive leaf in the corridor door set 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 inactive leaf in the door set was open and not secured at the time of the observations. The inactive leaf was equipped with a lever inside the side of the door at the meeting edges of the door set. The lever had to be manually flipped in order 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 the time of	K 0363	**K 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The Community failed to ensure that Spa door and the office door by the Cypress Run Nurse Station to the corridor would shut and latch properly. The Maintenance Supervisor removed the items propping the doors open so they shut and latch properly. Observation 2- The community failed to ensure that the doorway to the administrative office by the therapy gym had compliant and latching door hardware. The Maintenance Supervisor has secured the secondary leaf of the door so it will not open. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents 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**	07/21/2025

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	each of the observations, the Maintenance Supervisor agreed the aforementioned three corridor door locations each had an impediment to closing and latching into the door frame. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**recur.** Observation 1 and 2- There is a TELS task to inspect all corridor doors every month to ensure that they close and latch properly. See attached TELS task labeled "Morristown Door Inspection TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect these areas during their annual Corporate Quality Review to ensure all doors in the community shut and latch properly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 electrical panels in the 700 Hall corridor was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are	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 Community failed to ensure that the electrical panel near resident room 701 was properly locked from unauthorized entry. The Maintenance Supervisor has secured the electrical panel.	07/21/2025

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	guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect over 5 residents, staff and visitors in the 700 Hall. Findings include: Based on observations with the Maintenance Supervisor at 1:15 p.m. on 06/16/25, the wall mounted electrical panel in the corridor outside resident sleeping Room 701 in the 700 hall was not locked or otherwise secured from non-authorized personnel. Based on interview at 1:15 p.m. on 06/16/25, the Maintenance Supervisor agreed the wall mounted electrical panel in the corridor outside resident sleeping Room 701 in the 700 hall was not locked or otherwise secured from non-authorized personnel. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents on the 700 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 all electrical panels in the common areas to ensure they are locked. See attached TELS task labeled "Morristown Electrical Panel Locking TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all electrical panels during their annual Corporate Quality Review to ensure they are locked.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device Based on observation and interview, the facility failed to install 1 of 1 maintenance office fuel-fired	K 0522	**K 522**	07/21/2025

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	suspended heaters in accordance with LSC 19.5.2.2. LSC 19.5.2.2(1) states any heating device other than a central heating plant shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. This deficient practice could affect over 50 residents, staff and visitors in Morristown Manor. Findings include: Based on observations with the Maintenance Supervisor at 3:02 p.m. on 06/16/25, the natural-gas fired ceiling mounted suspended heater in the maintenance office in Morristown Manor was not equipped with a safety feature to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. The maintenance office was also the location for the dry sprinkler system riser for Morristown Manor and the suspended heater was most likely in place to ensure the riser location was maintained above 40 degrees Fahrenheit at all times. Based on interview at 3:02 p.m. on 06/16/25, the Maintenance Supervisor agreed the natural-gas fired ceiling mounted suspended heater was not equipped with a safety feature to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b)		**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 gas fired hanging heater had an emergency shut off right inside the door to this room. The Maintenance Supervisor is having an electrician put a stop switch on the power supply that feeds this unit. **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 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.** This is a permanent fix, and no further follow-up is needed. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent fix, and no further follow-up is needed.	

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K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the "Fire Policies and Procedures" section of "Emergency Disaster Preparedness" documentation dated 12/06/24 with the Maintenance Supervisor at 12:00 p.m. on 06/16/25, the written fire safety plan for the facility did not address the location of fire barrier doors or smoke barrier doors in the facility. The fire plan documentation stated "Insert Map of Fire Zones" but no map or fire zone documentation was included in the 12/06/24 written fire plan documentation to address the evacuation of smoke compartments. Based on interview at 12:00 p.m. on 06/16/25, the Maintenance Supervisor agreed the written fire safety plan for the facility did not address the location of fire barrier doors or smoke barrier doors in the facility.	K 0711	**K 711** **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 wall and smoke barrier map and locations were in the Emergency Disaster Preparedness Binder for review. The Maintenance Supervisor has placed the map in the binders. **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 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.** The Maintenance Supervisor has been reeducated on the fire barrier and smoke door map to ensure he knows all of there locations. **IV The facility will monitor the corrective action by**	07/21/2025

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	These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**implementing the following measures.** CarDon Corporate facilities will inspect the Emergency Preparedness and Life Safety Binder to ensure the fire barrier and smoke door map is current and in place.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the third shift for three of four calendar quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELs Logbook Documentation "Fire Drills" with the Maintenance Supervisor at 12:00 p.m. on 06/16/25, three of four third shift fire drills were not conducted at unexpected times under varying conditions for three of four calendar quarters. Documentation for third shift fire drills conducted within the most recent twelve month period on 06/22/24, 12/23/24 and on 03/13/25 stated the fire drill was conducted at, respectively, 10:37 p.m., 11:30 p.m. and 11:00 p.m. Based on interview at 12:00 p.m. on 06/16/25, the Maintenance Supervisor stated the facility mainly operates two shifts per day but he conducts fire drills for three shifts, additional third	K 0712	**K 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 shift fire drills had varying conditions and times. The Maintenance Supervisor has been re-educated on Fire Drills and to make sure they have varying conditions and 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 to be affected by this deficient	07/21/2025

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	shift fire drill documentation within the most recent twelve month period was not available for review and agreed the aforementioned third shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been reeducated on Fire Drills and 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 drill activation paperwork during their annual Corporate Quality Review to ensure that they are at varying times.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 1 outdoor areas where smoking was taking place. This deficient practice could affect over 1 staff. Findings include:	K 0741	**K 741** **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 an appropriate metal container to	07/21/2025

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	Based on observations with the Maintenance Supervisor at 2:48 p.m. on 06/16/25, an open top metal dispenser served as the repository for cigarette butts in the outdoor smoking area for employees outside the employee breakroom. Based on interview at 2:48 p.m. on 06/16/25, the Maintenance Supervisor stated the area was a staff smoking area and agreed a metal container with self-closing cover devices was not provided at this outdoor location where smoking was taking place. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		dispose of cigarette butts in near the employee smoking area. The Maintenance Supervisor has purchased a new metal trash can and self-closing lid. **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 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.** The Maintenance Supervisor has been reeducated on what appropriate containers are needed to properly dispose of cigarette butts. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect the smoking area during their annual Corporate Quality Review.	

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K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to document a complete written record of monthly generator load testing for 1 month of the most recent 12 month period in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 8.4.1 states Emergency Power Supply Systems (EPSS), including all appurtenant components shall be inspected weekly and exercised under load at least monthly. Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 99, 2012 Edition, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation with the Maintenance Supervisor at 12:00 p.m. on 06/16/25, weekly load testing documentation for December 2024 listed the "Run time" as "20" minutes. Based on interview at 12:00 p.m. on 06/16/25, the Maintenance Supervisor stated the facility has two separate emergency generators which are each LP gas-fuel fired, the facility conducts and documents weekly load testing for each generator, additional load testing documentation for December 2024 was not	K 0918	**K 918** **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 2 different generators at the community were maintained per NFPA standards. The Maintenance Supervisor has been re educated on the proper generator run times and the documentation needed. **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 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.** The Maintenance Supervisor has been re educated on the proper generator run times and the documentation needed. **IV The facility will monitor the corrective action by**	07/21/2025

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	available for review and agreed load testing documentation for generator load testing for December 2024 was not documented as a minimum of 30 minutes. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**implementing the following measures.** CarDon Corporate facilities will inspect all generator paperwork during their annual Corporate Quality Review to ensure that there are being maintained correctly.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring in 1 of 1 equipment rooms in the basement. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 5 residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Supervisor at 3:35 p.m. on 06/16/25, a coffee pot and a microwave oven were plugged into a power strip in the MDS Room. Based on observations with the Maintenance Supervisor at 3:59 p.m. on	K 0920	**K 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 were no appliances plugged into power strips within the community. The Maintenance Supervisor has removed the power strip from the 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 to be affected by this deficient practice. **III. The facility will put into**	07/21/2025

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	06/16/25, a coffee pot was plugged into a power strip identified as UL 1363A in the Cypress Run Administrative Office by the fireplace. Based on interview at 3:35 p.m. and at 3:59 p.m. on 06/16/25, the Maintenance Supervisor agreed power strips were being used as a substitute for fixed wiring at the aforementioned locations. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		**place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated on when and where power strips are able to be used within the community. There is a monthly TELS Task to inspect the community to ensure there are no power strips being used. See Attached TELS Task labeled "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 their annual Corporate Quality Review to ensure that there are no power strips in use.	
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 2 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or	K 0923	**K 923** **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	07/21/2025

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	gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect over 2 staff and visitors in the vicinity of the oxygen storage room near the maintenance office near the service corridor. Findings include: Based on observations with the Maintenance Supervisor at 2:55 p.m. on 06/16/25, the corridor entry door to the oxygen storage room by the maintenance office near the service corridor was equipped with an operable lock on the door handle to secure against unauthorized entry but the key to unlock the door was kept in the door handle while the room was unattended. The room contained five liquid oxygen containers and one 'E' type cylinders. Based on interview at 2:55 p.m. on 06/16/25, the Maintenance Supervisor stated he did not know where the key to the room is normally kept and agreed the oxygen storage room by the maintenance office near the service corridor was not locked or kept by other means to secure against unauthorized entry. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		Morristown Manor Oxygen room was locked and not accessible to individuals that are not permitted to be in that room. The Maintenance Supervisor has removed the key from the oxygen room and has educated the staff that the door needs to be locked and the key not accessible. **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 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.** The Maintenance Supervisor has in serviced the staff to ensure they are aware that all oxygen room doors need to remain locked at all times. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect both oxygen rooms during their annual Corporate Quality Review to ensure that the oxygen room door us shut and locked.	

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	155691	A. BUILDING 01 B. WING	06/16/2025

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K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Based on observation and interview, the facility failed to protect 2 of over 50 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. This deficient practice could affect over 2 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor at 9:17 a.m. during the initial walk through of the facility on 06/16/25, one liquid oxygen container was stored in resident sleeping Room 413. Based on observations with the Maintenance Supervisor at 3:33 p.m. on 06/16/25, the liquid oxygen container was still stored in resident sleeping Room 413. Based on observations with the Maintenance Supervisor at 1:55 p.m. on 06/16/25, two liquid oxygen containers were stored in resident sleeping Room 309. One of the liquid containers was being	K 0930	**K 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 of over 50 resident rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. The resident in room 413 no longer resides in the 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. The Fi02 is higher on the liquid oxygen container versus a concentrator. The tank in room 309 isn't used to 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 to be affected by this deficient practice.	07/21/2025

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	actively being used by one of the two residents of the room. Each of the two resident sleeping rooms were not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to each room was not self-closing or automatic closing. Each corridor door to the room was equipped with a 20-minute fire resistance rating label affixed to the top of the door. Based on interview at 1:55 p.m. on 06/16/25 and at 3:33 p.m. on 06/16/25, the Maintenance Supervisor agreed liquid oxygen containers were stored and in use in the rooms and each room was not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		**III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has in serviced the staff to ensure they are aware that liquid oxygen containers cannot be stored in resident rooms unless they are medically necessary and portables aren't being filled from them. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect resident rooms during their annual Corporate Quality Review to ensure that liquid oxygen is not being used.	
K 0000 Bldg. 02	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: 06/16/25 Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030	K 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on June 16, 2025. This letter is to inform you that the plan of correction attached is to serve as Morristown Manor'sy credible allegation of compliance. We are requesting paper compliance for this plan of correction.	

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	At this Life Safety Code survey, Morristown Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility consists of Building 01 constructed in 2000 and the attached Cypress Run addition identified as Building 02 constructed in 2010. Each building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 119 and had a census of 98 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has three detached storage buildings which were each not sprinklered. Quality Review completed on 06/24/25		If you have any further questions, please do not hesitate to contact me at 765-763-6012. Sincerely, Andrew Buzzard, HFA Administrator Morristown Manor	
K 0361 SS=E Bldg. 02	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms in Cypress Run were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be	K 0361	**K 361** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community	07/21/2025

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	open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Cypress Run Therapy Room. Findings include: Based on observations with the Maintenance Supervisor at 3:54 p.m. on 06/16/25, the inactive leaf in the corridor door set to 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 inactive leaf in the door set was open and not secured at the time of the observations. The inactive leaf was equipped with a lever inside the side of the door at the meeting edges of the door set. The lever had to be manually flipped in order 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 06/16/25, the Maintenance Supervisor agreed the corridor door set to the aforementioned Therapy Room was not equipped with a positive latching device on each door leaf to latch the door into the door frame. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference.		failed to ensure that the doorway to the therapy gym from the main corridor had compliant and latching door hardware. The Maintenance Supervisor has secured the secondary leaf of the door so it will not open. **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 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.** This is a permanent resolution to the issue so there will be no follow up needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will audit all doors during their annual Corporate Quality Review to ensure the therapy doors latch properly.	

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K 0754 SS=E Bldg. 02	3.1-19(b) NFPA 101 Soiled Linen and Trash Containers Based on observation and interview, the facility failed to ensure unattended soiled linen and trash receptacles stored in 1 of 11 means of egress were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Supervisor at 1:28 p.m. on 06/16/25, one unattended trash receptacle was stored in the breezeway outside the 800 Hall in Cypress Run. Documentation affixed to the lid for the receptacle indicated it was 44-gallon capacity. Based on interview at 1:28 p.m. on 06/16/25, the Maintenance Supervisor agreed the aforementioned receptacle was not being stored in a room protected as a hazardous area when unattended. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0754	**K 754** **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 trash receptacle in the Cypress Run 800 Hall had a lid on it. The Maintenance Supervisor has re-educated all staff that any waste receptacles or trash cans over 32 gallons needs to always have a lid on them and stored in 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 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.** The Maintenance Supervisor has re-educated all staff that any	07/21/2025

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			waste receptacles or trash cans over 32 gallons needs to always have a lid on them and stored in the correct room. See attached in-service paperwork **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all trash receptacles during their annual Corporate Quality Review to ensure they have lids on them and stored in the proper locations.	