STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING -- B. WING	05/22/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/22/23 Facility Number: 000217 Provider Number: 155324 AIM Number: 100289590 At this Emergency Preparedness survey, Mitchell Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 171 certified beds. At the time of the survey, the census was 49. Quality Review completed on 05/24/23	E 0000	K211 It is the intent of this facility that aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of an emergency. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were affected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents resided on this hallway. **What corrective measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** The bedside table and two stools by room 156 on C Wing was removed during the survey as referenced in the 2567. An all staff inservice was held on 5/26/23 to educate staff on the importance of maintaining unblocked means of egress. **How the corrective action will be monitored to ensure the**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathi HIgnite Owens	Executive Director	06/02/2023

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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			deficient practice will not recur, i.e. what quality assurance program will be put into place: Under the direction of the maintenance director, means of egress on each hallway will be monitored daily prior to stand up meeting. Audits to be completed 5x a week for four weeks, then three times a week for four weeks and weekly x 4 months. Any areas of noncompliance will be addressed immediately. Results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly x 6 months to identify trends and to make recommendations. Audits will continue based on QAPI recommendations. Frequency and/or duration of auditing will be increased for areas of noncompliance. The Administrator is responsible for implementing this acceptable plan of correction.	
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: 05/22/23 Facility Number: 000217	K 0000	K211 It is the intent of this facility that aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of	

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	155324	A. BUILDING 01 B. WING	05/22/2023

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	Provider Number: 155324 AIM Number: 100289590 At this Life Safety Code survey, Mitchell Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 171 and had a census of 49 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 05/24/23		an emergency. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were affected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents resided on this hallway. **What corrective measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** The bedside table and two stools by room 156 on C Wing was removed during the survey as referenced in the 2567. An all staff inservice was held on 5/26/23 to educate staff on the importance of maintaining unblocked means of egress. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Under the direction of the maintenance director, means of egress on each hallway will be monitored daily prior to stand up meeting. Audits to be completed 5x a week for four weeks, then three times a week for four weeks	

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			and weekly x 4 months. Any areas of noncompliance will be addressed immediately. Results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly x 6 months to identify trends and to make recommendations. Audits will continue based on QAPI recommendations. Frequency and/or duration of auditing will be increased for areas of noncompliance. The Administrator is responsible for implementing this acceptable plan of correction.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 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 10 residents and staff in C Wing. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 05/22/23	K 0211	K211 It is the intent of this facility that aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of an emergency. **What corrective actions will be accomplished for those**	05/31/2023

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	between 1:55 p.m. and 3:45 p.m., a bedside table and two stools were stored in the C Wing exit corridor in front of the exit door by room 156 at the end of the corridor. Based on an interview at the time of observations, the Maintenance Director agreed there was storage in the corridor and removed the bedside table and stools upon observation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the alleged deficient practice:** No residents were affected. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents resided on this hallway. **What corrective measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** The bedside table and two stools by room 156 on C Wing was removed during the survey as referenced in the 2567. An all staff inservice was held on 5/26/23 to educate staff on the importance of maintaining unblocked means of egress. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Under the direction of the maintenance director, means of egress on each hallway will be monitored daily prior to stand up meeting. Audits to be completed 5x a week for four weeks, then three times a week for four weeks and weekly x 4 months. Any areas of noncompliance will be addressed immediately.	

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			Results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly x 6 months to identify trends and to make recommendations. Audits will continue based on QAPI recommendations. Frequency and/or duration of auditing will be increased for areas of noncompliance. The Administrator is responsible for implementing this acceptable plan of correction.	
K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 87 of 87 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions.	K 0300	K300 Protection-Other It is the intent of this facility to ensure documentation for the preventative maintenance of 87 of 87 battery operated smoke alarms in resident rooms. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were affected by this alleged deficient practice. **How other residents having the**	05/31/2023

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	This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Battery Operated Smoke Detectors Maintenance Logs on 05/22/23 at 12:38 p.m. with the Maintenance Director present, the itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis was last documented July 2022. Monthly documentation of battery operated smoke alarm testing since July 2022 indicates '87 passed'. Based on interview at the time of record review, the Maintenance Director confirmed that the battery operated smoke detector testing has not been documented in an itemized list since July 2022. Based on observations between 1:55 p.m. and 3:45 p.m. during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents were affected by this alleged deficient paperwork practice. **What corrective measures will be put into place and what systemic changes will be made to ensure** the deficient practice does not recur: The maintenance director had completed monthly inspections of the Battery Operated Smoke Detectors and maintained a preventative maintenance log in the PM logbook. This log lacked an itemized list. The maintenance director was provided a copy of the battery operated smoke detector maintenance log to include an itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis. A monthly test was conducted on 87 of 87 battery operated smoke detectors and an itemized list on May 25, 2023. Any non-functioning unit will be addressed immediately. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** The monthly inspections of the	

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			Battery Operated Smoke Detector including itemized listing will be submitted by the Maintenance Director to the Quality Assurance Performance Improvement Committee monthly x 6 months. Audits will continue based on QAPI recommendations. Frequency and/or duration of monitoring will be increased for areas of non-compliance. The administrator is responsible for implementing this acceptable plan of correction.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 17 hazardous areas such as central supply rooms was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 5 residents, staff and visitors in the vicinity of the Central Supply room in the Education Wing. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:55 p.m. to 3:45 p.m. on 05/22/23, the corridor door to the Central Supply room across the hall from the Laundry was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When swinging to close, the door slowed down as it dragged on the carpeting, not allowing the door to latch into the frame. Based on interview at the time of observation, the Maintenance Director confirmed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	K 0321	K321 It is the intent of this facility that hazardous areas are protected by a fire barrier having 1-hour fire resistance rating or an automatic fire extinguishing system. Doors shall be self-closing or automatic closing. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Any residents could be affected by the alleged deficient practice. **What corrective measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** The corridor door to the Central Supply room across the hall from the laundry was equipped with a	05/31/2023

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	3.1-19(b)		self-closing device. The Maintenance Director adjusted the door on 5/25/23 allowing the door to close without catching on the carpet. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Under the direction of the maintenance director, the door will be checked twice daily Monday through Friday x 30 days, weekly x 4 weeks and monthly thereafter for a total of 6 months to ensure the self-closer is allowing the door to close and lock. Results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly x 6 months to identify trends and to make recommendations. Audits will continue based on QAPI recommendations. Frequency and/or duration of auditing will be increased for areas of noncompliance. The Administrator is responsible for implementing this acceptable plan of correction.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to maintain the ceiling construction in the entire facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observations with the Maintenance Director on 05/22/23 during a tour of the facility from 1:55 p.m. to 3:45 p.m., the following was observed: a) there was a one inch by one half inch opening in the ceiling next to the escutcheon of the ceiling mounted sprinkler in the linen closet across the corridor from room 162 b) in the mechanical room located in the Education Hall, an escutcheon was missing from the ceiling mounted sprinkler. An escutcheon ring was	K 0353	F353 It is the intent of this facility to ensure maintenance and testing automatic sprinkler and standpipe systems in accordance with NFPA29. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Approximately 20 residents and staff could have been affected by this alleged deficient practice. **What corrective measures will be put into place and what systemic changes will be made**	05/31/2023

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	observed on the floor of the mechanical room. These conditions could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of the observations, the Maintenance Director confirmed the aforementioned findings and stated that he was unaware of the missing escutcheon and opening in the ceiling. This finding was discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		**to ensure the deficient practice does not recur:** A one inch by one inch opening in the ceiling next to the escutcheon of the ceiling mounted sparkler in the linen closet across the corridor from room 162 was replaced. In the mechanical room located in the education hall, the missing escutcheon ring was replaced on the ceiling mounted sprinkler. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** Under the direction of the maintenance director, walking rounds will be conducted on one hallway per day Monday-Friday to check for missing escutcheon rings x 30 days and weekly thereafter for a total of 6 months to ensure any missing or fallen escutcheon rings are replaced immediately. Results of these audits will be forwarded to the Quality Assurance and Performance Improvement Committee monthly x 6 months to identify trends and to make recommendations. Audits will continue based on QAPI recommendations. Frequency and/or duration of auditing will be increased for areas of noncompliance. The administrator is responsible for implementing this acceptable	

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			plan of correction.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 2 wet locations observed were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance	K 0511	K511 Utilties, Gas and Electric It is the intent of this facility that equipment using gas or related gas piping complies with NFPA 54. **What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents were affected by the alleged deficient practice. The GFCI outlet was located in an employee breakroom. **What corrective measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur:** The GFCI outlet located in the employee breakroom was	05/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155324	A. BUILDING 01 B. WING	05/22/2023

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

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	with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only. Findings include: Based on observation on 05/22/23 during a tour of		replaced and tested by a GFCI tester by the maintenance director on May 26, 2023. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** GFCI outlets will be tested monthly as part of the preventative maintenance program and results of the testing will be provided to the Quality Assurance Performance Improvement Committee x 6 months. Audits will continue based on QAPI recommendations. Any GFCI outlets noted to be faulty will be replaced immediately. Frequency and/or duration of auditing will be increased for areas of noncompliance. The Administrator is responsible for implementing this acceptable plan of correction	

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	the facility with the Maintenance Director from 1:55 p.m. to 3:45 p.m., there was a GFCI outlet within five feet of a sink in the employee breakroom. When tested with a GFCI tester, the GFCI outlet tested "open ground" and would not trip the circuit. Based on interview at the time of observation, the Maintenance Director confirmed the outlet showed open ground and would not trip the circuit. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			