STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING -- B. WING	07/05/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/05/23 Facility Number: 000299 Provider Number: 155676 AIM Number: 100286940 At this Emergency Preparedness survey, Milner Community Health Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 80 certified beds. At the time of the survey, the census was 52. Quality Review completed on 07/07/23	E 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
richard Jackson	administrator	07/26/2023

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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	155676	A. BUILDING -- B. WING	07/05/2023

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

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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

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	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based	E 0039	1. District 4 Health Care Coalition contacted and assistance with table top exercise requested. Table top exercise scheduled for July 26, 2023 10a-12p with assistance of the Health Care Coalition. 2. All other testing has been completed timely. 3. Bi-annual testing will be reviewed on pm schedule in December. If testing for prior year is not completed, it will be scheduled within the next 3 months. 4. QAPI committee will review preventative maintenance manual annually to assure all testing is planned.	07/26/2023

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	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the document entitled "Disaster Manual - Milner Community Health Care" on 07/05/23 at 11:06 a.m. with the Director of Maintenance (DOM), there was no: second full-scale exercise that is community-based or an individual, facility-based functional exercise, mock disaster drill, or tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan available for review. Based on an interview at the time of record review, the DOM stated that they had not yet scheduled or conducted a second exercise as of this time. During the exit conference with the facility Administrator and the DOM at 2:18 p.m., no additional information or evidence could be provided contrary to this deficient finding.			

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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: 07/05/23 Facility Number: 000299 Provider Number: 155676 AIM Number: 100286940 At this Life Safety Code survey, Milner Community Health Care was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a two-hour separation from an assisted living occupancy located on the west side of the building. The west emergency exit from A Hall requires passing through one smoke compartment of the assisted living unit. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and in all resident rooms. The facility has a capacity of 80 and had a census of 52 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for the	K 0000	Submission of this Plan of Correction and Credible Allegation of Compliance does not constitute an admission by the certified and licensed provider at Milner Community Health Care, Inc that the allegations contained in this survey report are true and accurate portrayal of the provisions of nursing care and services at this facility. Milner Community Health Care , Inc. as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economical and efficient fashion. Please accept this Plan of Correction as the Credible allegation of compliance.	

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	one detached storage shed, and one garage storage area which are not sprinklered. Quality Review completed on 07/07/23			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 6 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.1 Delayed-Egress Locking Systems allows approved, listed, delayed-egress locks shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (1) The door leaves shall unlock in the direction of egress upon activation of one of the following: (a) Approved, supervised automatic sprinkler system installed in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detections system in accordance with section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection	K 0271	1. Egress door sited was adjusted to proper sensitivity. 2. All other egress doors checked and passed. 3. All egress doors were added to preventative maintenance schedule and will be tested monthly. 4. Maintenance Director will report preventative maintenance outcomes monthly to QAPI Committee for 6 months.	07/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 01 B. WING	07/05/2023

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

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	system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4) A readily visible, durable sign in letters not less than 1 in. (25mm) high and at least 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". (5) The egress side of the doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with 7.9. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations made during a tour of the facility on 07/05/23 with the Director of Maintenance (DOM), at 1:56 p.m., the East Hall exit near the Beauty Shop exit was provided with			

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	155676	A. BUILDING 01 B. WING	07/05/2023

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	delayed egress locks and were provided with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door, however, when the doors were pushed, the irreversible process to release the lock was not initiated. This was acknowledged by the Maintenance Director at the time of observations who added that he would have the door adjusted as soon as he could or contact his vendor to do so. During the exit conference with the facility Administrator and the DOM at 2:18 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
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			

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	155676	A. BUILDING 01 B. WING	07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Area Automatic Sprinkler Separation N/A 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)			
	1) Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 6 hazardous areas, such as a House Keeping/Bio-hazard room or a storage room of combustible supplies over 50 square feet in size, was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect as many as 14 residents, 4 staff and 2 visitors. Findings include: Based on observations made during a tour of the facility on 07/05/23 with the Director of Maintenance (DOM), at 1:47 p.m., resident room #D 9 had been converted into a storage room. This room measured approximately 190 square feet in size and contained: numerous boxes of latex gloves, patient gowns, hand sanitizer, packages of adult diapers, and miscellaneous boxes of other personal protective equipment and supplies. The corridor door to this room did not have a self-closing device installed on it. The lack of a functioning self-closing device was acknowledged by the DOM at the time of observation who added that he would have one	K 0321	1. Automatic door closer installed to converted resident room and door stop removed from Medical Records office. 2. These are the only room falling into sited category and all other stops have been removed from facility. 3. Staff in-serviced on no door stop facility policy. Monthly door preventative maintenance amended to add checks on door closures and to verify no door stops are being used. 4. Maintenance Director will notify QAPIi Committee monthly for 6 months.	07/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155676	A. BUILDING 01 B. WING	07/05/2023

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

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installed so soon as possible.

During the exit conference with the facility Administrator and the DOM at 2:18 p.m., no additional information or evidence could be provided contrary to this deficient finding.

3.1-19(b)

2) Based on observation and interview, the facility failed to ensure 1 of 6 corridor doors to a hazardous area were provided with a means suitable for keeping the door closed, had no impediment to closing, latching, and would resist the passage of smoke. This deficient practice could affect 14 residents, 4 staff and 2 visitors.

Findings include:

Based on observations made during a tour of the facility on 07/05/23 with the Director of Maintenance (DOM), at 1:40 p.m., the Medical Records office, a room greater than 50 square feet that contained hundreds of medical records and patient charts was propped in the open position with a door wedge. Based on interview at the time of observation, the DOM acknowledged the aforementioned corridor door to a hazardous room was propped in the fully open position with a door wedge adding that he has asked staff not to prop open the door, but they continue to do so to the door to this office.

During the exit conference with the facility Administrator and the DOM at 2:18 p.m., no additional information or evidence could be provided contrary to this deficient finding.

3.1-19(b)

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	155676	A. BUILDING 01 B. WING	07/05/2023

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

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review on 07/05/23 with the Director of Maintenance (DOM), at 11:50 a.m., documentation for a smoke detector sensitivity test within the last two-year period was not available for review. Based on interview at the time of record review, the DOM acknowledged the	K 0345	1. Sited inspection results were located with appropriate sensitivity parameters attached. 2. This was only testing data missing. 3. Testing company notified that sensitivity data needs to be attached annually to testing document. Maintenance Director will add specific documentation needed to preventative maintenance schedule to ensure proper paperwork is received. 4. QAPI committee to review the sensitivity data for the next 2 years of inspections to ensure proper documentation is present.	07/24/2023

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	155676	A. BUILDING 01 B. WING	07/05/2023

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

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	aforementioned condition and confirmed no other documentation was available from his vendor as of the time of this survey. Furthermore, the DOM stated that he would have his vendor out as soon as he could schedule the testing. During the exit conference with the facility Administrator and the DOM at 2:18 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0353 SS=F 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 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 record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 0353	1. Contracted company notified and scheduled data retrieval needed to apply for hydraulic name plate. Company indicated they would need 30 days to	09/15/2023

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	155676	A. BUILDING 01 B. WING	07/05/2023

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

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	Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review of the testing document entitled "Quarterly Water Based Fire Protection System Inspection" documentation dated 07/21/22, 10/12/22, 01/11/23, and 04/21/23 during record review with the Director of Maintenance (DOM) from 11:25 a.m. to 11:35 a.m. on 07/05/23, the following was noticed: a) In the deficiencies area of all four aforementioned inspections stated, "Hydraulic nameplate - FAIL "The Hydraulic nameplate is missing." b) In the deficiencies area of all four aforementioned inspections stated, "Recalled sprinkler heads are scattered throughout the building. Based on interview at the time of record review, the DOM stated that he could not provide any documentation showing that the hydraulic nameplate or the recalled sprinklers had been replaced as of the time of this survey During the exit conference with the facility Administrator and the DOM at 2:18 p.m., no		complete needed tasks for replacement of name plate. 2. Other side of sprinkle head system, hydraulic name plate in place. 3. After name plate replaced by contracting agency, maintenance will review inspection paperwork annually to ensure successful passing by contracted company. Company also sent contract to continue replacement of recalled sprinkler heads, as one side of facility has been replaced. 4. Administrator will provide updates to the QAPI committee quarterly until all sprinkler heads have been replaced and name plate has been properly placed.	

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	155676	A. BUILDING 01 B. WING	07/05/2023

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

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	additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			