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	12/01/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 12/01/16 Facility Number: 000217 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 483.70(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, consisting of Building 0101 and Building 0202 each constructed prior to 2003, 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 and in all areas open to the corridor. The facility has battery operated smoke	K 0000	This Plan of Correction is prepared and executed because of the provisions of state and federal law requires it and not because Mitchell Manor agrees with the allegations and citations listed. Mitchell Manor maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character to limit our capabilities to render adequate care. Please accept this Plan of Correction as our credible allegation of compliance, that the alleged deficiencies cited have been or will be corrected by the date(s) indicated. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following Plan of Correction. *****We request a paper compliance / desk review for this survey*****	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	detectors in all resident sleeping rooms. The facility has a capacity of 171 and had a census of 55 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached garage and two storage barns providing facility storage services which were not sprinklered. Quality Review completed on 12/05/16 - DA			
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 was 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, staff and visitors if needing to exit the facility using the Education Wing corridor. Findings include:	K 0211	K- 211 It is the policy of this facility to maintain aisles, passageways, corridors, exit discharges, exit locations, and accesses in accordance with chapter 7. 1. The folding table has been removed to allow ease of access to individuals who would potentially utilize the Education Hall emergency exit as a means of egress. 2. 100% of facility egress corridors	12/02/2016

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	Based on observation with the Plant Operations Manager during a tour of the facility from 11:55 a.m. to 2:10 p.m. on 12/01/16, one three foot wide by six foot long collapsible table was stored in the Education Wing corridor which was marked as facility exit corridor with exit signs. The table was standing upright with the legs in the fully open position and projected three feet into the eight foot wide corridor. Based on interview at the time of observation, the Plant Operations Manager acknowledged 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. 3.1-19(b)		were reviewed and any items protruding into the corridor that were not secured to the floor have been removed. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will educate facility staff to keep 8 foot clearance in egress corridors. Education will also be included with annual fire safety training. Maintenance Director or designee will tour all egress corridors weekly to ensure they are free from projections. 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or Designee will report on results of tours during monthly QI committee meeting for 4 consecutive months.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation, the facility failed to meet the clear width requirement for 2 of 10 corridors or met an exception per	K 0232	K- 232 It is the policy of this facility	12/02/2016

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	19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5)(d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised		to maintain the exit aisles so that projections do not reduce the path of travel to less than 6 feet and that they are securely attached to the floor in accordance with LSC 19.2.3.4(2). 1. The table outside room 157 has been removed to allow ease of access to individuals who would potentially utilize the C Wing corridor as a means of egress. The 2 benches remain in the Main Dining Room corridor but have been secured and do not reduce the travel path to less than 6 feet. 2. 100% of facility egress corridors were reviewed and any items protruding into the corridor that were not secured to the floor or that reduced the travel path to less than 6 feet have been removed. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will educate facility staff to keep 8 foot clearance in egress corridors or 6 feet clearance in instances where hall furniture is securely attached to the floor. Education will also be included with annual fire safety training. 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director of designee will tour all egress corridors	

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	automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 30 residents, staff and visitors if needing to exit the facility. Findings include: Based on observation with the Plant Operations Manager during a tour of the facility from 11:55 a.m. to 2:10 p.m. on 12/01/16, the C Wing and the northeast corridor outside the Main Dining Room each measured eight feet in clear width. A two foot wide by three foot long table was stored in the C Wing corridor outside Room 157 and was not affixed to the floor or to the wall. Two five foot long by two feet wide wooden benches were stored in the northeast corridor outside the Main Dining Room and were not affixed to the floor or to the wall. Based on interview at the time of the observations, the Plant Operations Manager acknowledged furniture was stored in the aforementioned two corridors which was not affixed to the floor or to the wall. 3.1-19(b)		weekly to ensure they are free from obstructions. Maintenance Director or Designee will report on results of tours during monthly QI committee meeting for 4 consecutive months.	

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K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 2 of 6 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observation with the Plant Operations Manager at 11:00 a.m. on 12/01/16, the battery operated emergency light at the emergency transfer switch location failed to function when its respective test button was pushed five times. At 2:00 p.m. during a tour of the facility, the battery light affixed to the corridor wall outside Room 213 in the	K 0291	K- 291 It is the policy of this facility to maintain battery powered emergency lights in accordance with LSC 7.9. 1. The battery operated emergency light located at the transfer switch has been replaced and the battery operated light affixed to the corridor wall outside room 213 is no longer required and has been removed. 2. 100% of facility battery powered emergency lights have been assessed and all are functioning properly. All battery operated lights in the facility are currently tested weekly. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will continue monitoring proper function of battery powered emergency lighting weekly. 4. Monitoring to ensure alleged deficient practice does not recur:	12/31/2016

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	Williams Wing failed to function when its respective test button was pushed five times. Based on interview at the time of the observations, the Plant Operations Manager stated battery operated lights in the facility are tested weekly but acknowledged the aforementioned two battery operated emergency lights failed to function when its respective test button was pushed. 3.1-19(b)		Maintenance Director or designee will present weekly battery powered emergency light tests to the QI committee monthly for 4 consecutive months.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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			

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	door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation 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 K3220)			
	Based on observation and interview, the facility failed to ensure the corridor door to 1 of 9 hazardous areas such as Laundries larger than 100 square feet was separated from other spaces by smoke resistant partitions and doors. This deficient practice could affect 10 residents, staff and visitors if needing to exit the facility by the Laundry. Findings include: Based on observation with the Plant Operations Manager during a tour of the facility from 11:55 a.m. to 2:10 p.m. on 12/01/16, a one half inch in diameter hole was noted above the door handle in the corridor door to Laundry by the east exit of the facility. Based on interview at the	K 0321	K- 321 It is the policy of this facility to ensure that corridors are protected from hazardous areas b smoke resistant partitions and doors. 1. The ½ inch hole in the laundry door has been sealed with intumescent caulk. 2. 100% of facility fire doors have been inspected and no other penetrating openings were identified. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will visually inspect all fire doors	12/09/2016

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	time of observation, the Plant Operations Manager stated the door handle was recently replaced and acknowledged a one half inch in diameter hole was noted above the door handle in the corridor door to the aforementioned hazardous area. 3.1-19(b)		monthly to ensure that there are no penetrating openings and corrective actions will be taken promptly for any concerns identified during inspection. 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will present monthly fire door inspection results to the QI committee monthly for 4 consecutive months.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.			

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	18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. Section 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance.	K 0324	K- 324 It is the policy of this facility to ensure that the kitchen exhaust systems are inspected semiannually. 1. The exhaust hood has been inspected 4 times in 2016. Inspections were conducted in January, March, July, and December. Documentation of all 2016 hood inspections have been obtained from our service provider and will be maintained in the Maintenance Office for review. 2. The exhaust hood has been inspected 4 times in 2016. Inspections were conducted in January, March, July, and December. Documentation of all 2016 hood inspections have been obtained from our service provider and will be maintained in the Maintenance Office for review. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will meet with ED quarterly to review log books ensuring that proof of required inspections is on hand for review. 4. Monitoring to ensure alleged deficient practice does not recur:	12/09/2016

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	When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on record review with the Plant Operations Manager from 9:10 a.m. to 11:55 a.m. on 12/01/16, documentation of semiannual kitchen exhaust system inspection for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Plant Operations Manager acknowledged documentation of semiannual kitchen exhaust system inspection for the most recent twelve month period was not available for review. Based on observation with the Plant Operations Manager during a tour of the facility from 11:55 a.m. to 2:10 p.m. on 12/01/16, Richard's Hood & Duct had affixed a sticker to the range hood in the kitchen stating a kitchen exhaust systems inspection was conducted on 07/14/16 and the next scheduled inspection was due October 2016. Based on interview at the time of observation, the Plant Operations Manager stated		Maintenance Director or designee will present quarterly exhaust hood checks to the QI committee for 6 months.	

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	kitchen exhaust systems inspections are performed quarterly by Richards but acknowledged the 07/14/16 inspection was the only documented kitchen exhaust system inspection available for review for the most recent twelve month period. 3.1-19(b)			
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 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, observation, and interview; the facility failed to ensure 3 of over 100 sprinklers in the facility were replaced or cleaned in accordance with	K 0353	K- 353 It is the policy of this facility to ensure that the sprinkler system is inspected, tested, and maintained	12/31/2016

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	NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect 30 residents, staff and visitors. Findings include: Based on observations with the Plant Operations Manager during a tour of the facility from 11:55 a.m. to 2:10 p.m. on 12/01/16, the following was noted:		in accordance with NFPA 25. 1. The sprinkler head located behind the laundry room dryers has been cleared of lint. The sprinkler heads in the closet of room 101 and the closet of room 171 have been replaced. 2. 100% of the sprinkler heads in the facility have been visualized and are clear of dust, paint, or spackle. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will make monthly rounds to identify any sprinkler heads that may have paint or spackle on them. Sprinkler heads found to have debris on them will be corrected or corrective action will be arranged at the time of inspection. 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will present monthly sprinkler head audits to the QI committee for 4 consecutive months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	a. the one sprinkler located behind the Laundry room dryers was covered with lint. b. paint was on the deflector for the one sprinkler in the closet for Room 101. c. spackling compound was on the one sprinkler in the closet for Room 171. Based on interview at the time of the observations, the Plant Operations Manager acknowledged the aforementioned automatic sprinkler locations were loaded with lint, foreign materials or paint. 3.1-19(b)			
K 0911 SS=D Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 janitor's closets in the kitchen.	K 0911	K- 911 It is the policy of this facility to ensure that access / working space is maintained in enclosures housing electrical apparatus.	12/02/2016

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	12/01/2016

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	NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect five staff and visitors in the kitchen. Findings include: Based on observation with the Plant Operations Manager during a tour of the facility from 11:55 a.m. to 2:10 p.m. on 12/01/16, two electrical panels were noted on the wall of the janitor's closet in the kitchen. A four foot high by three feet wide plastic cabinet was stored against the wall underneath one of the electrical panels. In addition, a metal trash can, two bags containing water softener salt and a mop bucket were all		1. The plastic cabinet, metal trash can, mop bucket, and softener salts were moved so that 3 feet of working space is maintained around the electrical panels in the Kitchen Janitor closet. 2. 100% of the electrical panels in the facility have been visualized and are clear of encroachments of the required working space. 3. Systems to ensure alleged deficient practice does not recur: Maintenance Director or designee will make monthly rounds to identify items encroaching into the electrical housing working space for all facility electrical panels. Items encroaching within 3 feet will be moved during time of inspection. 4. Monitoring to ensure alleged deficient practice does not recur: Maintenance Director or designee will present monthly Electrical panel audits to the QI committee for 4 consecutive months.	

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	stored within three feet of the second electrical panel in the room. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned items were stored within three feet of the working space in front of electrical panels in the janitor's closet in the kitchen. 3.1-19(b)			