STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING -- B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE 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: 04/16/24 Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030 At this Emergency Preparedness survey, Morristown Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 119 certified beds. At the time of the survey, the census was 112. Quality Review completed on 04/18/24	E 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on April 16, 2024. This letter is to inform you that the plan of correction attached is to serve as Morristown Health and Living Community credible allegation of compliance. We allege substantial compliance on May 3, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-763-6012. Sincerely, Andrew Buzzard, HFA Administrator Morristown Manor	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/16/24 Facility Number: 000422 Provider Number: 155691	K 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on April 16, 2024. This letter is to inform you that the plan of correction attached is to serve as Morristown Health and Living Community credible allegation of compliance. We allege substantial compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Buzzard	Administrator	05/03/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	AIM Number: 100291030 At this Life Safety Code survey, Morristown Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility consists of Building 01 constructed in 2000 and the attached Cypress Run addition identified as Building 02 constructed in 2010. Each building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 119 and had a census of 112 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has three detached storage buildings which were each not sprinklered. Quality Review completed on 04/18/24		on May 3, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-763-6012. Sincerely, Andrew Buzzard, HFA Administrator Morristown Manor	
K 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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 5 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Section 7.5.2.2.1 states hangings or draperies shall not be placed over exit doors or located so that they conceal or obscure any exit, unless otherwise provided in 7.5.2.2.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit to the outside of the facility from the service corridor near the main dining room. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:30 a.m. to 9:50 a.m. on 04/16/24, two upholstered chairs and a desk were stored in the service corridor near the office area by the main dining room. A corridor door separated the office area corridor from the service corridor where the items were stored. The service area corridor door was marked as a facility exit with an exit sign and was also marked with the necessary delayed egress signage for a delayed egress door. Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, the two upholstered chairs and the desk were still stored in the service corridor. The corridor storage of these items blocked half of the six foot wide corridor width. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency due to the	K 0211	**K 221** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the service corridor was clear of items to maintain a 6ft clear path of egress. The Maintenance Supervisor has removed all items from the service corridor. See attached picture showing this corridor. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current weekly TELS task for this community to inspect all paths of egress to ensure they are clear. See attached TELS	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	storage of furniture in the service corridor. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		task labeled “Morristown Path of Egress TELS Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will audit all paths of egress during their annual Corporate Quality Review to ensure the service hallway is clear of debris.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility into the 500 Hall. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 9:30 a.m. to 9:50 a.m. on 04/16/24, the entrance door set to the 500 Hall was marked as a facility exit with an exit sign. The exit door set could be opened by entering a code into a keypad to release the door set to open but the code to release the door set to open was not posted at the exit door set. Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, the code to release the exit door set to open was still not posted at the exit door set into the 500 Hall. Based on interview at the time of the observations, the Maintenance Director stated the 500 Hall is a dedicated wing for Alzheimer's residents, the code had been posted at the entrance door set to the 500 Hall but agreed the exit door set to go into the 500 Hall was marked as a facility exit but the code to release the door set to open was not posted at the exit door set.	K 0222	**K 222** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the keypad code from the Manor Nurse Station into the secured memory care unit had the code posted. The Maintenance Supervisor has posted the code above the keypad. See attached picture showing the code posted. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent resolution to the issue so there will be no follow up needed.	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will audit all doors during their annual Corporate Quality Review to ensure all keypad codes are posted where needed.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation and interview, the facility failed to ensure only new sprinklers were available to be utilized for its sprinkler system. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.1.2.2 states reconditioned sprinklers shall not be permitted to be utilized on any new or existing system and Section 6.2.1 states only new sprinklers shall be installed. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, sidewall sprinklers were observed installed throughout the facility in resident sleeping rooms. The spare sprinkler cabinets located in the sprinkler riser room for the dry sprinkler system which services Morristown Manor (Building 01) contained a total of two sidewall spare sprinklers which each had the manufacture date of 2000 stamped on the deflector for the spare sprinkler. Based on interview at the time of observation, the Maintenance Director agreed both spare sidewall sprinklers were more than 20 years old. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0351	**K 351** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The community failed to ensure that the spare sprinkler head box in the riser room had up to date replacement sprinkler heads in there. The Maintenance Supervisor has purchased new sprinkler heads from Safecare and replaced. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated on the life expectance of sprinkler heads and when they need to be tested. **IV The facility will monitor**	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the corrective action by implementing the following measures. CarDon Corporate facilities will inspect the spare sprinkler head box during their annual Corporate Quality Review to ensure that there are no spare sprinkler heads that are out of date.	
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services 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, observation and interview; the facility failed to ensure 3 of 5 water heaters which require inspection certificates from the State of Indiana had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include:	K 0500	**K 500** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The Community failed to ensure that 3 of the 5 hot water heaters had current inspection reports and certificates. The Maintenance Supervisor has put new Certificate of inspections for the 3 hot water	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review with the Maintenance Director and the Maintenance Assistant from 9:50 a.m. to 12:45 p.m. on 04/16/24, current inspection certificates from the State of Indiana for all water heaters in the facility which require inspection certificates were not available for review. Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, the following water heaters did not have current Certificate of Inspection documentation from the State of Indiana: a. the water heater identified as IN315426. b. the water heater identified as IN315428. c. the water heater identified as IN363255. Expired Certificate of Inspection documentation from the State of Indiana was posted at each of the three water heater locations indicating IN315426 and IN315428 certificates expired 05/28/23 and the water heater identified as IN363255 certificate expired 05/26/23. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned water heaters did not have current Certificate of Inspection documentation from the State of Indiana. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		heaters in his life safety book and attached to the wall in the mechanical room. The new expiration date is May of 2025. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- There is a current 24 month TELS task that has been updated to notify the Maintenance Supervisor that the boiler certificates expire in May of 2025. . See attached TELS task labeled “Morristown Boiler Permit Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 01 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			inspect all boiler certificates during their annual Corporate Quality Review to ensure they have not expired.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/16/24 Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030 At this Life Safety Code survey, Morristown Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility consists of Building 01 constructed in 2000 and the attached Cypress Run addition identified as Building 02 constructed in 2010. Each building was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors	K 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on April 16, 2024. This letter is to inform you that the plan of correction attached is to serve as Morristown Health and Living Community credible allegation of compliance. We allege substantial compliance on May 3, 2024. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-763-6012. Sincerely, Andrew Buzzard, HFA Administrator Morristown Manor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 119 and had a census of 112 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has three detached storage buildings which were each not sprinklered. Quality Review completed on 04/18/24			
K 0351 SS=F Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only new sprinklers were available to be utilized for its sprinkler system. NFPA 13, Standard for the Installation of Sprinkler Systems,	K 0351	**K 351** **I. The corrective actions to be accomplished for those**	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2010 Edition; Section 6.1.2.2 states reconditioned sprinklers shall not be permitted to be utilized on any new or existing system and Section 6.2.1 states only new sprinklers shall be installed. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, sidewall sprinklers were observed installed throughout the facility in resident sleeping rooms. The spare sprinkler cabinets located in the sprinkler riser room for the dry sprinkler system which services Cypress Run (Building 02) contained a total of four sidewall spare sprinklers which each had the manufacture date of 2000 stamped on the spare sprinkler. Based on interview at the time of observation, the Maintenance Director agreed the four spare sidewall sprinklers were each more than 20 years old. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice.** Observation – The community failed to ensure that the spare sprinkler head box in the riser room had up to date replacement sprinkler heads in there. The Maintenance Supervisor has purchased new sprinkler heads from Safecare and replaced. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been re educated on the life expectance of sprinkler heads and when they need to be tested. **IV The facility will monitor the corrective action by implementing the following measures.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			CarDon Corporate facilities will inspect the spare sprinkler head box during their annual Corporate Quality Review to ensure that there are no spare sprinkler heads that are out of date.	
K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 54 fire extinguishers were accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, 6.1.3.1 states fire extinguishers shall be conspicuously located where they are readily accessible and immediately available in the event of fire. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the Cypress Run nurse's station. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, a crash cart was stored in the corridor up against the cabinet containing the wall mounted ABC type portable fire extinguisher which caused the extinguisher to not be readily accessible and immediately available in the event of fire. An	K 0355	**K 355** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation – The community failed to ensure that all the fire extinguishers we not blocked and readily accessible because the Cypress Run Crash Cart was blocking the fire extinguisher cabinet. The Maintenance Supervisor has in-serviced the Cypress Run staff on not to block any fire extinguisher cabinets. **II. The facility will identify other residents that may**	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	opened portable laptop computer stored on top of the crash cart partially obscured the fire extinguisher as well. Affixed maintenance tags on the portable fire extinguisher inside the cabinet indicated the most recent annual maintenance was performed by an inspection contractor in October 2023 and the facility also had documented monthly inspections through March 2024. Based on interview at the time of the observations, the Maintenance Director agreed the portable fire extinguisher was not readily accessible and immediately available in the event of fire. These findings were reviewed with the Maintenance Director during the exit conference 3.1-19(b)		**potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current weekly TELS task for this community to inspect all paths of egress to ensure there is nothing blocking the fire extinguisher cabinets. See attached TELS task labeled "Morristown Path of Egress TELS Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect all corridors during their annual Corporate Quality Review to ensure that there are no items blocking the fire extinguisher cabinets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0361 SS=E Bldg. 02	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observation and interview, the facility failed to ensure 1 of 1 therapy rooms in Cypress Run were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect over 5 residents, staff and visitors in the vicinity of the Cypress Run Therapy Room. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, the inactive leaf in the corridor door set to the Therapy Room in Cypress Run was not equipped with a positive latching mechanism to latch the door into the door frame when tested to close multiple times. The inactive leaf in the door	K 0361	**K 361** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation - The community failed to ensure that the doorway to the therapy gym from the main corridor had compliant and latching door hardware. The Maintenance Supervisor has secured the secondary leaf of the door so it will not open. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the community have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic**	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	set was open and not secured at the time of the observations. The inactive leaf was equipped with a lever inside the side of the door at the meeting edges of the door set. The lever had to be manually flipped in order to latch the door into the door frame. The active leaf in the door set was equipped with a positive latching device but would only latch into the inactive leaf if the inactive leaf was latched into the door frame. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door set to the aforementioned Therapy Room was not equipped with a positive latching device on each door leaf to latch the door into the door frame. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		**changes to ensure that the deficient practice does not recur.** This is a permanent resolution to the issue so there will be no follow up needed. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will audit all doors during their annual Corporate Quality Review to ensure the therapy doors latch properly.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 24 corridor doors to resident sleeping rooms in Cypress Run had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 8 residents, staff and visitors in Cypress Run. Findings include: Based on observations with the Maintenance Director and the Maintenance Assistant during a tour of the facility from 1:00 p.m. to 3:15 p.m. on 04/16/24, a hanger for the storage of a small amount of isolation supplies was affixed to the top	K 0363	**K 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation 1– The Community failed to ensure that resident room 802 door to the corridor shut and latched properly. The door would not shut due to a hanger over the top of the door that help isolation supplies. The Maintenance	05/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the corridor door to resident sleeping Room 802 in Cypress Run which caused the door to not latch into the door frame when tested to close multiple times. The door was able to latch into the door frame when the Maintenance Director removed the hanger. Based on interview at the time of the observations's, the Maintenance Director agreed the corridor door to resident Room 802 had an impediment to closing and latching into the door frame and would not resist the passage of smoke when the hanger was affixed to the top of the door. These findings were reviewed with the Maintenance Director during the exit conference. 3.1-19(b)		Supervisor has removed the hanger and isolation supplies from resident room 802 door. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents have the potential to be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Observation 1- There is a TELS task to inspect all corridor doors every month to ensure that they close and latch properly. See attached TELS task labeled "Morristown Corridor Door Inspection Task" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate facilities will inspect these areas during their annual Corporate Quality Review to ensure all doors in the community shut and latch	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. BUILDING 02 B. WING	04/16/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			properly.	