

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING -- _____ B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(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
--------------------	--	---------------	---	----------------------

E 0000 Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 02/07/23</p> <p>Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030</p> <p>At this Emergency Preparedness survey, Morristown Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.</p> <p>The facility has 119 certified beds. At the time of the survey, the census was 111.</p> <p>Quality Review completed on 02/09/23</p>	E 0000	<p>This plan of correction is to serve as Morristown Manor's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Morristown Manor or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p>Morristown Manor respectfully requests a desk review for the plan of correction.</p>	
E 0041 SS=F Bldg. --	<p>482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew Buzzard	Administrator	02/24/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p> <p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 02/07/2023
NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 868 S WASHINGTON ST MORRISTOWN, IN 46161		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	
	<p>Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>During record review and interview with the Maintenance Supervisor on 2/7/23 between 10:15 a.m. and 12:50 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour test. This was confirmed by the Maintenance Supervisor, who stated after speaking with the facilities contractor, the test has not been done.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p>	E 0041	<p>E 041</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation - The community failed to ensure that there was a documented 3-year, 4 hour run test completed on each generator. The Maintenance Supervisor will complete such run test. See attached documentation showing each generator. Attachment A</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents in the community have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>There has been a new TELS task added for this community to</p>	02/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>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).</p> <p>Survey Date: 02/07/23</p> <p>Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030</p> <p>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.</p> <p>This one story facility consists of Building 01</p>	K 0000	<p>ensure that the 3-year, 4 hour run test takes place. See attached TELS task labeled "3 Year Generator Run Test Task"</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate facilities will also review this information during their annual Corporate Quality Review to ensure the run test have taken place.</p> <p>This plan of correction is to serve as Morristown Manor's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Morristown Manor or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. Morristown Manor respectfully requests a desk review for the plan of correction.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0321 SS=E Bldg. 01	<p>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 111 at the time of this visit.</p> <p>All areas where residents have customary access were sprinklered. The facility has three detached storage buildings which were each not sprinklered.</p> <p>Quality Review completed on 02/09/23</p> <p>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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Area Automatic Sprinkler Separation N/A</p> <p>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)</p> <p>Based on observation and interview, the facility failed to maintain protection of 1 of 1 hot oil popcorn popper in the Life Enrichment Area. This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include:</p> <p>Based on observations and interview during a facility tour with the Maintenance Supervisor on 02/07/23 between 12:50 p.m. and 3:45 p.m., a hot oil popcorn popper was being stored the Life Enrichment Area. When asked where the machine was used the Maintenance Supervisor stated the hot oil popcorn popper was used in the area where it was being stored. The Life Enrichment Area did not have a self-closing device installed and is open to the corridor.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p>	K 0321	<p>K 321</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation – The community failed to ensure that the hot oil popcorn popper was being used in the appropriate area. The life enrichment area did not have a door closer on it and is open to the corridor. The Maintenance Supervisor has added spring hinges to this door. Attachment B</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents that use the life enrichment area have the</p>	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/07/2023
NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 868 S WASHINGTON ST MORRISTOWN, IN 46161		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0363 SS=E Bldg. 01	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		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 educated the staff that the popcorn popper can only be used in this area and with the new spring hinges it needs to remain shut at all times. Attachment C IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate facilities will inspect this area during their annual Corporate Quality Review to ensure that the pop corn popper is only being used in this area and the door to the corridor is kept shut.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>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.</p> <p>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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>Based on observation and interview, the facility failed to ensure all resident room corridor doors 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 8 staff.</p>	K 0363	<p>K 363</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient</p>	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(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
	<p>Findings include:</p> <p>Based on observations and interview during a facility tour with the Maintenance Supervisor on 02/07/23 between 12:50 p.m. and 3:45 p.m., the (1) kitchen spruce hall corridor door had a 1-2 inch gap along the jamb side of the door and which even when closed would not be smoke tight. Additionally, the (2) aforementioned door would not latch positively into the door frame. Furthermore, (3) the Copy room door leading into the office area, equipped with a self-closing hinge, failed to self-close and latch and was being held open with a trash can.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p>		<p>practice.</p> <p>Observation 1– The Community failed to ensure that the kitchen spruce door leading to the hall would close and latch properly. The Maintenance Supervisor has ordered a new door and frame from Kelly Brothers. Attachment D Once replaced, the community will notify Life Safety that is has been completed.</p> <p>Observation 2- There Community failed to ensure that the copy room door in the front office would close and latch on its own because it was being held open by a trash can. The Maintenance Supervisor has removed the trash can.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have		<p>Observation 1- There is a TELS task to inspect all corridor doors every 3 months to ensure that they close and latch properly. See attached TELS task labeled "corridor door inspection task" Attachment E</p> <p>Observation 2- The maintenance Supervisor has educated the associates that use the copy area not to prop the door open with a trash can. Attachment F</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate facilities will inspect these areas during their annual Corporate Quality Review to ensure all doors in the community shut and latch properly.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9</p> <p>Based on observation and interview, the facility failed to ensure 1 of over 10 smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 15 staff and residents.</p> <p>Findings include:</p> <p>Based on observations and interview during a facility tour with the Maintenance Supervisor on 02/07/23 between 12:50 p.m. and 3:45 p.m., the 90-minute door in the firewall assembly of the East Service Hall corridor failed to self-close and latch when tested several times.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p>	K 0374	<p>K 374</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation 1– The Community failed to ensure that the 90-minute door in the east service hall would close and latch properly. The Maintenance Supervisor has ordered a new door and frame from Kelly Brothers. See attached order. Attachment D Once replaced, the community will notify Life Safety that it has been completed.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents have the potential to be affected by this deficient practice.</p>	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP COD 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 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility	K 0511	<p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Observation 1- There is a TELS task to inspect all corridor doors every 3 months to ensure that they close and latch properly. See attached TELS task labeled "corridor door inspection task" Attachment E</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate facilities will inspect these areas during their annual Corporate Quality Review to ensure all doors in the community shut and latch properly.</p>	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location.</p> <p>(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.</p> <p>(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors</p> <p>Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.</p> <p>Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection.</p> <p>(5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink.</p>		<p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation 1– The community failed to ensure that the kitchen ice machine was plugged into a GFI outlet. The Maintenance Supervisor has replaced that outlet with a GFI. See attached picture. Attachment G</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All kitchen staff have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Observation 1- This is a permanent fix and not follow up will be needed.</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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
	<p>Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection.</p> <p>Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required.</p> <p>(6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools.</p> <p>NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 5 staff in kitchen area.</p> <p>Findings include:</p> <p>Based on observations and interview during a facility tour with the Maintenance Supervisor on 02/07/23 between 12:50 p.m. and 3:45 p.m., the ice machine in the kitchen area was connected to an electric receptacle which was being used to power the freestanding ice machine, with it's own water supply. The ice machine was located within 2 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI).</p> <p>The Maintenance Supervisor at the time of observation stated he did not believe the receptacle was on a GFCI circuit.</p>		CarDon Corporate Facilities will inspect these areas during their annual Corporate Quality Review to ensure all ice machines within the community are GFI protected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP COD 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 0521 SS=F Bldg. 01	<p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p> <p>NFPA 101 HVAC HVAC</p> <p>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2</p> <p>Based on record review, observation and interview; the facility failed to ensure fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall then be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be</p>	K 0521	<p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation 1– The Community failed to ensure that the fire dampers were inspected and documented every 4 years. On the March of 2021 inspection form there was a deficiency on the 125 Hall Restroom fire damper. No documentation of that repair could be located. The Maintenance Supervisor found the documentation concerning the repair. See attached documentation. Attachment H</p>	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/07/2023
NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 868 S WASHINGTON ST MORRISTOWN, IN 46161		
(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 0761 SS=E Bldg. 01	<p>documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>During record review and interview with the Maintenance Supervisor on 02/7/23 between 10:15 a.m. and 12:50 p.m., the most recent report of the inspection of the facility's fire and smoke dampers dated 03/11/21 stated repairs were needed to the location identified as "125 Hall Restroom". No documentation was provided confirming the needed repairs/replacements had been made since the facilities inspection. The Maintenance Supervisor stated he was unaware of the inspection having a failing appliance and that to his knowledge the faulty damper had not been repaired or replaced; noting that all took place prior to his employment at the facility.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p> <p>Based on records review, and interview, the</p>	K 0761	<p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Observation 1- There is a current TELS task to have the next fire damper inspection completed in 2025. See attached TELS task labeled "Fire Damper Inspection" Attachment I</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate Facilities will review the next fire damper report in 2025 to ensure all the deficiencies are taken care of.</p>	02/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	---	---

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

(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
--------------------	--	---------------	---	----------------------

	<p>facility failed to ensure annual inspection and testing of at least 1 fire door assembly was completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:</p> <ol style="list-style-type: none"> (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. 		<p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation 1– The Community failed to ensure that the annual fire door inspection included an inspection of the oxygen transfilling room. Cardon Corporate Facilities has re inspected this door and has updated their paperwork to include this door inspection. Attachment J</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff that use the oxygen transfilling room have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Observation 1- There is a current TELS task to have the next Annual Fire Door Inspection completed in 2024. See attached TELS task labeled "Morristown</p>	
--	--	--	---	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(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
	<p>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.</p> <p>(8) Latching hardware operates and secures the door when it is in the closed position.</p> <p>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.</p> <p>(10) No field modifications to the door assembly have been performed that void the label.</p> <p>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 10 residents.</p> <p>Findings include:</p> <p>During record review and interview with the Maintenance Supervisor on 02/7/23 between 10:15 a.m. and 12:50 p.m., no documentation of a current annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. The most recent report clearly itemizing the inspection of the Oxygen room door was from 2019. Current 2022 documentation entitled "Annual Fire Door Inspection Itemization" listed doors with letters, however none of the listed letters corresponded with the legend on the corresponding facility map. The Maintenance Supervisor agreed stating that he could not from the provided report verify that the Oxygen room door was inspected during the annual fire door inspections.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p>		<p>Annual Door Inspection" K</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate Facilities will review the current fire door inspection documentation during their next CQR to ensure that all doors that meet the inspection requirements are on there.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP COD 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 0918 SS=F Bldg. 01	<p>NFPA 101</p> <p>Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing</p> <p>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power</p>	K 0918	K 918	02/24/2023
----------------------------	---	--------	--------------	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/07/2023
NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 868 S WASHINGTON ST MORRISTOWN, IN 46161		
(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	
	<p>Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.</p> <p>Findings include:</p> <p>During record review and interview with the Maintenance Supervisor on 02/7/23 between 10:15 a.m. and 12:50 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour test. This was confirmed by the Maintenance Supervisor, who stated after speaking with the facilities contractor, the test has not been done.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p>		<p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation - The community failed to ensure that there was a documented 3-year, 4 hour run test completed on each generator. The Maintenance Supervisor has completed such run test. See attached documentation showing the completed run test for each generator. Attachment M</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and residents in the community have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>There has been a new TELS task added for this community to ensure that the 3-year, 4 hour run test takes place. See attached TELS task labeled "3 Year Generator Run Test Task"</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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 0781 SS=E Bldg. 02	<p>NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect up to 5 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations and interview during a facility tour with the Maintenance Supervisor on 02/07/23 between 12:50 p.m. and 3:45 p.m., a portable space heater was in use in the Cyprus Private Dining Room. Based on interview at the</p>	K 0781	<p>Attachment N</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate facilities will also review this information during their annual Corporate Quality Review to ensure the run test have taken place.</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Observation 1– The Community failed to ensure that there were no space heaters being used withing the community. There was a space heater in Cyprus dining</p>	02/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2023
--	---	---	---

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

(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
	<p>time of the observations, the Maintenance Supervisor agreed a space heater was located in the Private Dining Room and that the appliance was not allowed in the facility. No documentation was available for review to show the heating element temperature of the appliance did not exceed 212 degrees.</p> <p>This finding was acknowledged by the Maintenance Supervisor at the time of discovery and again at the exit conference with the Maintenance Supervisor and Administrator both present.</p> <p>3.1-19(b)</p>		<p>room and the Maintenance Supervisor has removed it.</p> <p>II. The facility will identify other residents that may potentially be affected by the deficient practice.</p> <p>All staff and associates that use the Cyprus Dining Room have the potential to be affected by this deficient practice.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>Observation 1- There is a current TELS task to inspect the community during winter months to ensure no space heaters are being used. See attached TELS task labeled "Portable Heater Inspection" Attachment L</p> <p>IV The facility will monitor the corrective action by implementing the following measures.</p> <p>CarDon Corporate Facilities will inspect the entire community during their next CQR to ensure that there are no space heaters being used.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/09/2023
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155691	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/07/2023
NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR			STREET ADDRESS, CITY, STATE, ZIP COD 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	