

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 03/24/2023
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NAME OF PROVIDER OR SUPPLIER MORRISTOWN MANOR	STREET ADDRESS, CITY, STATE, ZIP COD 868 S WASHINGTON ST MORRISTOWN, IN 46161
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E 0000 Bldg. --	<p>A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 02/07/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 03/24/23</p> <p>Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030</p> <p>At this PSR 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.</p> <p>Quality Review completed on 03/28/23</p>	E 0000	<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>	
K 0000 Bldg. 01	<p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/07/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 03/24/23</p> <p>Facility Number: 000422 Provider Number: 155691 AIM Number: 100291030</p> <p>At this PSR Life Safety Code survey, Morristown</p>	K 0000	<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</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrew	Buzzard	04/27/2023

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.

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K 0363 SS=E Bldg. 01	<p>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 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 03/28/23</p> <p>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</p>		<p>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>				

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	<p>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 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> <p>Findings include:</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 practice. The Community failed to ensure that the kitchen spruce door leading to the hall would close and latch properly. The Maintenance Supervisor has</p>	04/14/2023

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K 0374 SS=E Bldg. 01	<p>Based on observations and interview during a facility tour with the Maintenance Supervisor on 03/24/23 between 2:25 p.m. and 3:15 p.m., the 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.</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 present.</p> <p>This deficiency was cited on 02/07/23. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p> <p>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 fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not</p>		<p>ordered a new door and frame from Kelly Brothers. Attachment A. Once replaced, the community will notify Life Safety that is has been completed.</p> <p>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.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</p> <p>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 properly.</p>	

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	<p>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 03/24/23 between 2:25 p.m. and 3:15 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. The Maintenance Supervisor stated that the new doors had been ordered but not yet arrived.</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 present.</p> <p>This deficiency was cited on 02/07/23. The facility failed to implement a systemic plan of correction to prevent recurrence.</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. 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 A. Once replaced, the community will notify Life Safety that is has been completed.</p> <p>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.</p> <p>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur. 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 B</p> <p>IV. The facility will monitor the</p>	04/18/2023

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

PRINTED: 05/10/2023
FORM APPROVED
OMB NO. 0938-039

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			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 properly.		