

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

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

K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/26/16</p> <p>Facility Number: 000493 Provider Number: 155728 AIM Number: 100291300</p> <p>At this Life Safety Code survey, Manderley Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 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 was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 50 at the time of this visit.</p>	K 0000		
------------------------	---	--------	--	--

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037		
(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 0018 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled.</p> <p>Quality Review completed on 03/04/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. 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 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 staff room corridor doors would resist the passage of smoke. This deficient practice affects nursing staff who work at the center nurses station.</p>	K 0018	<p>1 Wood filler was used to repair door on 3/11/2016 2 No residents were effected by this deficiency 3 Maintenance staff will perform an annual inspection on all doors 4 Maintenance supervisor and facility Administrator will monitor all inspection logs and ensure</p>	03/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(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 0025 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observations on 02/26/16 at 1:15 p.m. with the maintenance supervisor, the center nurse 's station restroom corridor door had three, one half inch diameter holes in the door near the top of the door. This was verified by the maintenance supervisor at the time of observation and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 attic smoke barriers were maintained to provide a one half hour fire resistance rating. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p>	K 0025	<p>annual inspections are being done. See attachment #1 5. Completion date: 03/26/2016</p> <p>1 On 02/27/2016 Fire caulk and insulating foam sealant Fireblock along with drywall used to seal any gaps and holes where wires and sprinklers pipes poke through smoke barriers 2 South hall has the potential to effect all residents that would attend activities or meals in the dining room. North hall could effect 18 residents East hall could effect</p>	03/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(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>Based on observations with the maintenance supervisor on 02/26/16 during observations of the attic smoke barriers from 1:35 p.m. to 2:15 p.m., the following attic smoke barriers were not fire stopped;</p> <p>a. The West Hall attic smoke barrier had two, one inch gaps around cable bundles and two, three inch gaps around sprinkler water pipe penetrations not fire stopped.</p> <p>b. The East Hall attic smoke barrier had five, one quarter inch gaps around cable bundle and electrical conduit penetrations and a three inch gap around a sprinkler pipe penetration not fire stopped.</p> <p>c. The North Hall attic smoke barrier wall had a three, one half inch gaps around cable bundle penetrations and a three inch gap around a sprinkler pipe penetration not fire stopped.</p> <p>d. The South Hall attic smoke barrier wall had six, one half inch gaps around cable bundle penetrations and a three inch gaps around a sprinkler pipe penetration not fire stopped.</p> <p>The West Hall, East Hall, North Hall and South Hall attic smoke barrier penetrations not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p>		<p>11 residents West hall could effect 21 residents 3. Maintenance staff will perform an annual inspection on all smoke barriers to ensure no penetration has been made. 4. Maintenance supervisor will monitor all inspection logs and ensure annual inspections are being performed See attachment #1 5 Completion date: 03/26/2016 Addendum On 03/28/2016 insulating foam sealant Fireblock was removed and gaps were filled with fire caulk. Completion date 03/28/2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(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 0050 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to conduct quarterly fire drills on all shifts for 1 of 4 quarters over the past year. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of Monthly Fire Drill Reports with the maintenance supervisor on 02/26/16 at 10:20 a.m., there was no fire drill documentation for the third shift, fourth quarter of the year 2015. Additionally, based on interview with the maintenance supervisor during the review of the Monthly Fire Drill Reports, there was no other documentation available for review to verify this drill was conducted.</p>	K 0050	<p>1 Effective immediately after inspection 02/26/2016 we will use a calendar listing the month and what shift fire drill is to be performed. 2. All residents have the potential to be effected. 3. Maintenance supervisor will perform all fire drills using the calendar that was put in place 02/26/2016 4. Maintenance supervisor and the administrator will over see that all fire drills are being performed each month. See attachment #2 5. Completion date: 03/26/2016</p>	03/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037		
(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 0062 SS=F Bldg. 01	<p>This was verified by the maintenance supervisor at the time of record review and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on record review and interview, the facility failed to ensure 1 of 1 sprinkler system components was inspected quarterly for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents in the facility.</p>	K 0062	<p>1 Effective immediately following inspection 02/26/2016 Maintenance staff will perform a monthly inspection ensuring sub contractors are performing quarterly inspections 2 All residents have the potential to be effected. 3. Maintenance staff will perform monthly checks 4. Maintenance supervisor and facility administrator will ensure monthly check list are being performed. See attachment #3 5. Completion date: 03/26/16</p>	03/26/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037		
(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 Quarterly Sprinkler System Inspection Reports with the maintenance supervisor on 02/26/16 at 10:15 a.m., there was no fourth quarter (October, November, December) report for the year 2015 sprinkler system inspection report available for review. Based on interview with the maintenance supervisor on 02/26/16 during record review, the maintenance supervisor indicated there was no written documentation or other evidence the sprinkler system had been inspected during the fourth quarter of 2015. Based on observation of the sprinkler riser, located in the sprinkler riser room in the Service Hall on 02/26/16 at 11:50 a.m. with the maintenance supervisor, there was no written evidence on the sprinkler system inspection tag indicating a fourth quarter sprinkler inspection was conducted for the year 2015. This was verified by the maintenance supervisor at the time of record review and observation of the sprinkler riser and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace or clean 3 of over 300 sprinklers in the facility loaded</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(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 0067 SS=F Bldg. 01	<p>and covered in dust. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 32 residents who use the main dining room, located adjacent to the kitchen and 2 staff who work in the laundry room located in the Service Hall.</p> <p>Findings include:</p> <p>Based on observations on 02/26/16 during a tour of the facility with the maintenance supervisor from 11:10 a.m. to 2:30 p.m., the Service Hall laundry room had two sprinklers completely covered in dust and the kitchen had one sprinkler above the automatic dish washing machine completely covered in dust. This was verified by the maintenance supervisor at the time of observations and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016	
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037			
(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 0144 SS=F	<p>comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 6 of 6 egress corridors were not being used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply return or exhaust air system serving adjoining areas. This deficient practice affects all resident in the facility.</p> <p>Findings include:</p> <p>Based on observations on 02/26/16 during a tour of the facility from 11:10 a.m. to 2:30 p.m. with the maintenance supervisor, all rooms in the facility used the egress corridors as a return air system. This was verified by the maintenance supervisor at the time of observations and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 0067	<p>1. Maintenance staff cleaned all sprinkler heads</p> <p>2. All residents and staff as well as visitors have the potential to be affected.</p> <p>3. Maintenance staff will continue during quarterly inspections to ensure all heads are clean and free of tarnish and debris 4. Maintenance supervisor and facility administrator will ensure all sprinkler heads inspections are completed See attachment #4 5. Completion date: 03/26/2016</p>	03/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016	
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037			
(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			
Bldg. 01	<p>Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.</p> <p>3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generator was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This</p>	K 0144	<p>1 Maintenance staff will keep a weekly log of the generator performance. 2. All residents have the potential to be affected 3. Maintenance staff will keep a log every Monday morning recording the generator performance. 4. Maintenance supervisor and facility administrator will monitor generator log monthly to ensure weekly checks are being performed. See attachment #5 5. Completion date: 03/26/2016</p>	03/26/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
--	---

(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>deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review and an interview with the maintenance supervisor on 02/26/16 at 10:20 a.m., the Emergency Generator Monthly Load Test Log indicated a monthly load test conducted over the past year from February 2015 through 12/01/15 with no load test conducted for January 2016. Based on an interview with the maintenance supervisor at the time of record review, the facility had a load bank test conducted on 12/10/15 and the testing company indicated since an annual load bank test was conducted, monthly load testing is no longer required. The lack of a monthly load test for January 2016 was verified by the maintenance supervisor at the time of record review and interview and acknowledged at the exit conference on 02/26/16 at 2:35 p.m.</p> <p>3.1-19(b)</p>			