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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING		COMPL	ETED
		155728	B. W	ING		04/15/	/2024
	PROVIDER OR SUPPLIER RLEY HEALTH CAF			806 S E	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OD, IN 47037	•	(X5)
PREFIX				PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
	,	ICY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ATE	
TAG E 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	BEFELENCTI		DATE
E 0000 Bldg	conducted by the Ir accordance with 42 Survey Date: 04/15 Facility Number: 04/15 Facility Number: 100 At this Emergency Manderley Health Compliance with En Requirements for Naticipating Provided 483.73. The facility has 71 the survey, the censure of the survey in	5/2024 000493 155728 291300 Preparedness survey, Care Center was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR certified beds. At the time of	E 00	000	The facility recognizes that is must persuade your office the appropriate systems are in place to assure ongoing compliance with the federal regulations for participation the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary swill be taken to provide the best care possible to the residents at Manderley Healthcare. Preparation and execution of this plan of correction does not constituadmission or agreement by provider of the truth of the falleged or conclusions set for in the statement of deficiencies. This plan of correction is prepared and/of executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk revision the alleged deficiencies within this plan of corrections.	in teps tte the acts orth or s	
K 0000							
Bldg. 01	Licensure Survey w	Recertification and State was conducted by the Indiana lth in accordance with 42 CFR	K 0	000	The facility recognizes that i must persuade your office the appropriate systems are in		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement 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 disclodays 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u>01</u>	COMPLE	
		155728	B. W	'ING		04/15/2	2024
	ROVIDER OR SUPPLIER		•	806 S E	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST DD, IN 47037		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	483.90(a). Survey Date: 04/15 Facility Number: 0 Provider Number: 1002 At this Life Safety 0 Health Care Center with Requirements: Medicare/Medicaid. Life Safety from Fin National Fire Protect Life Safety Code (L. Health Care Occupation of the Company of this visit. All areas where residence of the Company of this visit.	6/2024 00493 155728 291300 Code survey, Manderley was found not in compliance for Participation in , 42 CFR Subpart 483.90(a), re and the 2012 Edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2. ity was determined to be of fuction and was fully cility has a fire alarm system on in the corridor, in all areas and has smoke detectors hard g electrical system in all oms. The facility has a had a census of 50 at the time			place to assure ongoing compliance with the federal regulations for participation the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary st will be taken to provide the best care possible to the residents at Manderley Healthcare. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facility alleged or conclusions set for in the statement of deficiencies. This plan of correction is prepared and/of executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk reviet for the alleged deficiencies within this plan of corrections.	eps te the acts orth r 6 f	
	detached building h	klered. The facility has a					
	_	ousing the facility's or which was fully sprinklered.					
	Quality Review con	npleted on 04/18/24					
K 0345	NFPA 101						
SS=F	Fire Alarm System	n - Testing and					
Bldg. 01	Maintenance	-					
	Fire Alarm System	n - Testing and					
	Maintenance	-					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7MYX21 Facility ID: 000493

If continuation sheet Page 2 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	01	COMPLETED	
		155728	B. W	ING		04/15/2024	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROJUDENC NAME CONDUCTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
IAU	A fire alarm syster in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N 1. Based on record of facility failed to main accordance with Code as required by 9.6. NFPA 72, Sect otherwise permitted shall be performed a schedules in Table 2 by the authority hav states that the followinspected semi-annua. Control unit troub. Remote annuncia c. Initiating devices fire alarm boxes, he etc.) d. Notification applie. Magnetic hold-op This deficient practic occupants. Findings include: During record revied Director on 04/15/2 1:45 PM, no docum regarding a visual sinspection. The annual was completed on 0 at the time of record Supervisor stated here.	m is tested and maintained in an approved program are requirements of NFPA 70, Code, and NFPA 72, in and Signaling Code. In acceptance, maintenance adily available. FPA 70, NFPA 72 review and interview, the intain 1 of 1 fire alarm systems NFPA 72, National Fire Alarm of LSC Sections 19.3.4.5.1 and the tion 14.3.1 states that unless 1 by 14.3.2, visual inspections in accordance with the 14.3.1, or more often if required ring jurisdiction. Table 14.3.1 wing must be visually unally: ole signals actors (e.g. duct detectors, manual cart detectors, smoke detectors, sinnees	K 0	345	F345 Fire Alarm System-Test and Maintenance 1 The facility allegedly failed have a visual semi-annual fire alarm system inspection completed. The facility immediately contar Quality Fire Protection to schedule completion of the required visual fire alarm system inspection. Any identified concerns will be immediately addressed. The facility allegedly failed to maintain the fire alarm system assure that it had accurate time information. The facility immediately correct the time information in the fire alarm system to reflect the accurate time. 2 The alleged deficiency had the potential to affect all reside staff, or visitors in the facility be non were effected. The Maintenance Director completed a visual inspection	ed to	05/24/2024

NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER SITREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037 SUMMARY STATEMENT OF DEPICIENCIE FREETY (EACH DEPICIENCY MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICIENCY MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICIENCY MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICIENCY MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICIENCY MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICE MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICE MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICE MIST BE PRECEDED BY PLIL 7A0 COMPLETION PREFIX (EACH DEPICE MIST BE PRECEDED BY PLIL 7A0 COMPLETION PROVIDER PLANOE CORRECTOR (COMPLETION COMPLETION COM	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				ONSTRUCTION	(X3) DATE SURVEY		
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visitors. Findings include: Based on observation of the fire alarm control panel annunciator on 04/15/2024 at 1:51 PM during a tour of the facility with the Maintenance Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. K 0353 NFPA 101 I alarm system and vaildate the fire alarm system inspection is in the maintenance binder x 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. K 0353 NFPA 101						1	_	
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Findings include: Based on observation of the fire alarm control panel annunciator on 04/15/2024 at 1:51 PM during a tour of the facility with the Maintenance Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. K 0353 NFPA 101 Accurate time and review the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance Director/Adminstrator pontinue for no less than 3 months and compliance is achieved. The Maintenance Direct		visitors.				1	fire	
Based on observation of the fire alarm control panel annunciator on 04/15/2024 at 1:51 PM during a tour of the facility with the Maintenance Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 2:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. K 0353 NFPA 101 maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder x 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. K 0353 NFPA 101		F: 1: : 1 1				1		
Based on observation of the fire alarm control panel annunciator on 04/15/2024 at 1:51 PM during a tour of the facility with the Maintenance Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 2:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. K 0353 NFPA 101		Findings include:					the	
during a tour of the facility with the Maintenance Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) binder x 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.		Based on observation	on of the fire alarm control					
Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. X 0353 NFPA 101		panel annunciator o	on 04/15/2024 at 1:51 PM			inspection is in the maintenan	ce	
indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. K 0353 NFPA 101		during a tour of the	facility with the Maintenance			binder x 12 weeks. This will		
fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. K 0353 NFPA 101		Supervisor, the time	e on the fire alarm control panel			continue for no less than 3 mc	onths	
PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. X 0353 NFPA 101 Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required. X 0353 NFPA 101						and compliance is achieved.		
interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. X 0353 NFPA 101 will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.						The Maintenance		
Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. X 0353 NFPA 101 Maintenance Supervisor agreed the fire alarm control panel committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.		_				Director/Administrator/Designe	ee	
control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. X 0353 NFPA 101 Committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.						1	e	
annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. X 0353 NFPA 101 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.		_	_			audits monthly to the QAPI		
This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) K 0353 NFPA 101 identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.		_	-					
This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) K 0353 NFPA 101 initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.		annunciator display	red the incorrect times.			-	I	
and the Maintenance Supervisor at the exit conference. 3.1-19(b) K 0353 NFPA 101 determine when 100% compliance is achieved or if ongoing monitoring is required.								
conference. 3.1-19(b) K 0353 NFPA 101						l ·		
3.1-19(b) monitoring is required. K 0353 NFPA 101			ee Supervisor at the exit			•	ance	
3.1-19(b) K 0353 NFPA 101		conference.						
		3.1-19(b)				monitoring is required.		
	K U3E3	NEDA 101						
			- Maintenance and Testing					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155728		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/15/2024	
	ROVIDER OR SUPPLIER		806 S I	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OD, IN 47037	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 01	Automatic sprinkles are inspected, test accordance with Nonspection, Testing Water-based Fire Records of system inspection and test secure location and a) Date sprinkler. b) Who provided b) Who provided c) Water system coverage for any result automatic sprinkles sprinkles secure location and a) Date sprinkles secure location and a) Date sprinkles coverage for any result automatic sprinkles sprinkles sprinkles shower room 1, 1 of 1 kitch bathroom near the dwomen's bathroom with rust/corrosion edition, at 5.2.1.1.1 of leakage; shall be materials, paint, and be installed in the coup-right, pendent, of 5.2.1.1.2 any sprink the following shall 1 Corrosion (3) Physithe glass bulb heat recould affect any result shower room 1, kitch shower r	supply source RKS information on non-required or partial or system.	K 0353	F353-Sprinkler System-Maintenance and Testing 1. The facility allegedly failed to ensure 1 of 2 sprinkler heads in shower room 1, 1 of 1 sprinkler heads in kitchen storage rooms of 1 men's bathroom sprinkler heads near the dining room an of 1 women's bathroom near the dining room were free of rust/corrosion. The facility immediately address the alleged deficiency by order the replacement sprinkler head and will install them immediate upon receipt. The facility allegedly failed to	n r s, 1 d 1 ne ssed ing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLE	ETED
		155728	B. W	'ING		04/15/2	2024
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
NAANDEE	N EV 11E AT TH OAE	DE CENTED			BUCKEYE ST		
MANDER	RLEY HEALTH CAF	RE CENTER		OSGOO	DD, IN 47037		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					ensure 1 of 1 sprinkler system	ıs	
	Findings include:				was maintained with spare		
	_				sprinklers, a spare sprinkler		
	Based on observation	on during a tour of the facility			cabinet and a spare sprinkler		
on 04/15/2024 between 1:45 PM and 4:00 PM with				wrench on the premises.			
	the Maintenance Supervisor, 1 of 2 sprinkler				·		
		om 1, 1 of 1 kitchen storage			The facility immediately obtain	ned	
	rooms, 1 of 1 men's	bathroom near the dining			and initiated compliance with		
		omen's bathroom near the			spare sprinkler cabinet, spare		
	dining room were c	overed with corrosion/rust.			sprinkler wrench and spare		
		at the time of observation, the			sprinkler supported within the		
	Maintenance Super	visor agreed there was			cabinet upon receipt of order.		
	corrosion/rust on the aforementioned sprinkler						
	heads.				The facility allegedly failed to		
					maintain ceiling construction in	n 2	
	This finding was re	viewed with the Administrator			locations shower room 1.		
	and the Maintenanc	e Supervisor at the exit					
	conference.				The construction of the ceiling	in	
					the 2 locations of shower roon	n 1	
	3.1-19(b)				will be repaired upon receipt o	of the	
					sprinkler head installation.		
	2. Based on observa	ation and interview, the facility					
	failed to ensure 1 of	f 1 sprinkler systems was					
	maintained with spa	are sprinklers, a spare sprinkler					
	cabinet and a sprink	der wrench on the premises.					
		for the Inspection, Testing,			2 The alleged deficient pra	ctice	
		f Water-Based Fire Protection			has the potential to affect all		
	•	ion, Section 5.4.1.4 states a			residents, staff and visitors an	d	
		nklers (never fewer than six)			non were effected.		
		on the premises so that any			The Maintenance Director		
	sprinklers that have	been operated or damaged in			completed an audit of all sprin	kler	
	any way can be pro	mptly replaced. The sprinklers			heads, ensured a spare with a	a	
	-	the types and temperature			spare cabinet and wrench wer		
		tlers on the property. The			place, and all ceiling construct	tion	
	_	cept in a cabinet located where			for concerns. Any identified		
	-	which they are subjected will at			concerns were immediately		
		degrees Fahrenheit. A special			addressed.		
	_	all be provided and kept in the					
		n the removal and installation			3 The Administrator comple	eted	
	of sprinklers. This deficient practice could affect				a 1:1 education with the facility	y	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155728		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 04/15/2024	
	ROVIDER OR SUPPLIER		806 S I	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OD, IN 47037	
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR all residents and star Findings include: Based on observation with the Maintenance Administrator on 04 4:00 PM, there was utility service room however the spare supported within the were sitting on top of cabinet. Based on ir observation, the Mathe spare sprinkler have within the spare sprinkler have within the spare sprinkler have been supported by the spare sprinkler have bea	EE CENTER STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION If in the facility. In during a tour of the facility the Supervisor and In 15/2024 between 1:45 PM and In a spare sprinkler cabinet in the In with spare sprinkler heads, In prinkler heads were not It is spare sprinkler cabinet and In the shelves within the Interview at the time of Interview at the time of Interview are not supported	806 S I	BUCKEYE ST	ing nee Connet, ench, esure This 3
	temperature. Section between the sprinkle above shall be select sprinkler and the type deficient practice of	to operate at a specified in 8.5.4.1.1 states the distance are deflector and the ceiling ted based on the type of the of construction. This hould affect several staff and same smoke compartment as			

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155728	B. W	ING		04/15/	/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				SUCKEYE ST		
MANDER	RLEY HEALTH CAR	E CENTER			DD, IN 47037		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0362 SS=E Bldg. 01	on 04/15/2024 between penetration of 3/8 in ceiling near the spri shower room 1 and inch was observed in shower room 1. Bas observation, the Mathe penetrations were measurements of the This finding was resupervisor and Admiconference. 3.1-19(b) NFPA 101 Corridors - Constraction Corridors - Constraction Corridors are sepawalls constructed in resistance rating. Compartments, paresist the transfer nonsprinklered buunderside of the floceiling. Corridor wunderside of ceiling permitted by Code Fixed fire window are in accordance sprinklered comparestrictions in area or frames. If the walls have a the rating	viewed with the Maintenance ninistrator at the exit uction of Walls uction of Walls uction of Walls arated from use areas by with at least 1/2-hour fire In fully sprinklered smoke rititions are only required to of smoke. In ildings, walls extend to the oor or roof deck above the alls may terminate at the gs where specifically					

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	BER A. BUILI B. WING		onstruction 01	(X3) DATE SURVEY COMPLETED 04/15/2024	
	PROVIDER OR SUPPLIE			806 S	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OD, IN 47037		
(X4) ID PREFIX TAG	brief description is ceiling throughout 19.3.6.2, 19.3.6.2. Based on observating failed to ensure concompartments in the resist the transfer of could affect over 1 in the vicinity the Tailed on observation 04/15/2024 between the Maintenance String and near rowinterview at the time Maintenance Super rooms 102 and 105 cords and the pener TV that had been publication in it during device attached to the This finding was recompliance.	on and interview, the facility ridor walls in 2 of 5 smoke he facility were constructed to of smoke. This deficient practice 5 residents, staff, and visitors TV lounge and the 100 hallway. on during a tour of the facility ween 1:45 PM and 4:00 PM with supervisor, penetrations of 9/16 were observed in the TV oms 105 and 102. Based on the of observations, the rvisor stated penetrations near is were due to the passage of tration in TV lounge was for a present previously. The rvisor stated each hall had a te to a cord being run to a	K 0	ID PREFIX TAG	F362 Corridors-Construction Walls 1 The facility allegedly faile ensure corridor walls in 2 of 5 smoke compartments in the facility were constructed to res the transfer of smoke. The facility immediately correc the alleged deficient practice t ensure construction of the 2 o 5 smoke compartments in the facility were resistant to transf smoke. 2 The alleged deficient pra has the potential to affect over residents, staff, and visitors in vicinity of the TV lounge and to 100 hallways and non were effected. The Maintenance Director completed an audit of all corrie walls to ensure smoke compartments were construct to resist the transfer of smoke Any identified concerns were immediately addressed. 3 The Administrator comple a 1:1 education with the facility Maintenance Director regardir the requirements to meet	of ed to sist cted to ut of ctice r 15 the he dor ed .	(X5) COMPLETION DATE 05/24/2024
					NFPA101. 4 The Maintenance		

Director/Administrator/Designee

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE A. BUILDING B. WING	construction <u>01</u>	(X3) DATE SURVEY COMPLETED 04/15/2024	
		133720		ET ADDRESS, CITY, STATE, ZIP COD	04/13/2024	
	PROVIDER OR SUPPLIE RLEY HEALTH CAI		806	806 S BUCKEYE ST OSGOOD, IN 47037		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION	
				will complete one day a wer rounds to ensure smoke compartments are construct resist the transfer of smoke weeks. This will continue for less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designal present the results of the audits monthly to the QAPI committee for no less than months. Any patterns that identified will have an Action initiated. The QAPI committed termine when 100% com is achieved or if ongoing monitoring is required.	ted to for 12 r no gnee ese 3 are n Plan ee will	
K 0521 SS=F Bldg. 01	comply with 9.2 a accordance with specifications. 18.5.2.1, 19.5.2.1 Based on observatifailed to ensure 4 cused as a portion of heating, ventilating ductwork serving a requires air condition ductwork and relating accordance with N Installation of Air	on, and air conditioning shall and shall be installed in the manufacturer's 1, 9.2 on and interview, the facility of 4 egress corridors were not f a return air system/plenum for g, or air conditioning (HVAC) adjoining areas. LSC 19.5.2.1 oning, heating, ventilating ed equipment to be installed in FPA 90A, Standard for the Conditioning and Ventilating 0A, 2012 Edition, Section	K 0521	K521 HVAC 1 The facility allegedly factorized and the facility allegedly factorized as a portion return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductive serving adjoining areas.	ors of a r	
		gress corridors shall not be used		The facility immediately ren	ewed	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	ľ í	UILDING	onstruction 01	(X3) DATE COMPL 04/15 /	ETED
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	as a portion of a sup system serving adjo	pply, return, or exhaust air bining areas unless otherwise		TAG	their Life Safety Code Waiver.		DATE
		.1.3.1 through 4.3.12.1.3.4. This bull affect all residents, staff			1 The alleged deficient pra has the potential to affect all residents, staff and visitors an	d	
	Findings include: Based on interview during record review on				non were effected. The facility immediately renewed their Life Safety Code Waiver Request	Э	
	Based on interview during record review on 4/15/2024 between 11:15 AM and 1:45 PM, the Maintenance Supervisor stated the facility has a waiver for the fire/smoke dampers and the system				The Administrator complete a 1:1 education with the facility Maintenance Director regarding	y	
	waiver for the fire/smoke dampers and the system shuts down with fire alarm system activation. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:45				the requirements to meet NFPA90A and LSC 19.4.2.1		
	PM to 4:00 PM, all	resident sleeping rooms and all wing were using the egress			3 The Maintenance Director/Administrator/Designo will validate Life Safety Code Waiver is in place and not exp		
		e reviewed with the he Maintenance Supervisor erence.			weekly for 12 weeks. This wi continue for no less than 3 mc and compliance is achieved.	II	
	3.1-19(b)	cronce.			The Maintenance Director/Administrator/Designor will present the results of thes audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action F initiated. The QAPI committee determine when 100% compli- is achieved or if ongoing monitoring is required.	e Plan will	
K 0920 SS=D Bldg. 01	Extens	ent - Power Cords and ent - Power Cords and					

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CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155728	A. BU B. W.	JILDING	01	04/15	
		155726	D. W			04/13/	72024
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
MANIDEI		DE CENTED			BUCKEYE ST		
MANDEI	RLEY HEALTH CAF	RE CENTER		USGU	OD, IN 47037		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		patient care vicinity are only					
	used for compone						
		ed electrical equipment les that have been					
	` '	alified personnel and meet					
		10.2.3.6. Power strips in					
		cinity may not be used for					
		, personal electronics),					
	, -	m care resident rooms that					
	1	E. Power strips for PCREE					
		r UL 60601-1. Power strips					
	for non-PCREE in the patient care rooms						
		meet UL 1363. In					
	1 '	ooms, power strips meet					
	1	ls. All power strips are					
		precautions. Extension					
	_	d as a substitute for fixed					
		re. Extension cords used					
	_	moved immediately upon					
	completion of the	purpose for which it was					
	installed and mee	ts the conditions of 10.2.4.					
	10.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8					
		(D) (NFPA 70), TIA 12-5					
		on and interview, the facility	K 0	920	K920 Electrical		05/24/2024
		f 1 power strips in room 204			Equipment-Power Cords and	t	
		ubstitute for fixed wiring. LSC			Extensions		
	_	ties to comply with Section 9.1.			1 The facility allegedly faile		
	1	electrical wiring and equipment			ensure 1 of 1 power strips in r		
		PA 70, National Electrical Code,			204 was not used as a substit	.ute	
		A 70, Article 400.8 requires that,			for fixed wiring.		
		permitted, flexible cords and			The Maintenance Director		
		used as a substitute for fixed			immediately removed the pow		
	_	e. LSC Section 4.5.7 states any			strip from room 204 and the n	HITH	
		uipment or safeguard provided be designed, installed, and			fridge was plugged into fixed		
	1	ance with all applicable NFPA			wiring.	etico	
		9, Standard for Health Care			2 The alleged deficient pra	Cuce	
		tion, defines patient care areas			has the potential to affect residents, staff and visitors an	nd	
		health care facility wherein			non were effected.	ı u	
	as any pornon or a	mount care racinty wherein	1		HOH WELE EHELLEU.		I .

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patients are intended to be examined or treated.

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7MYX21

Facility ID: 000493

The Maintenance Director

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 01		01	COMPLETED		
		155728	B. WING		04/15/2024			
		1.00.20		_		0 1, 10,		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
NAME OF FROVIDER OR SUFFLIER					BUCKEYE ST			
MANDERLEY HEALTH CARE CENTER				OSGOOD, IN 47037				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Patient care vicinity	y is defined as a space, within a			completed an audit to ensure that			
	location intended for	or the examination and		power strips were not used as a		a		
	treatment of patient	ts, extending 6 ft (1.8 m)		substitute for fixed wiring. Any				
	beyond the normal	location of the bed, chair,		identified concerns were				
	table, treadmill, or	other device that supports the		immediately addressed.				
		nination and treatment. A		3 The Administrator completed				
		y extends vertically to 7 ft 6 in.		a 1:1 education with the facility				
		loor. NFPA 99, Section 10.4.2.3		Maintenance Director regarding				
	` ′	office appliances not			the requirements to meet			
		ed with grounding conductors			NFPA70, NFPA99, LSC 9.1.2	,		
		s shall be permitted provided			LSC19.5.1	,		
	they are not located	l within the patient care						
		cient practice could affect many			4 The Maintenance			
	residents, staff, and visitors			Director/Administrator/Designee		ee		
	130133110, 01321, 4113 1211010				will complete rounds to ensure			
	Findings include:				power strips are not used as a			
					substitute for fixed wiring as	•		
	Based on observation during a tour of the facility				follows: Rotating locations to			
	with the Maintenance Supervisor on 04/15/2024			include common areas, resident				
	between 1:45 PM and 4:00 PM, a mini fridge was			rooms, dining rooms, kitchen,				
	plugged into a power strip and not directly into			offices will be audited 3 days a				
	the wall in room 204. Based on interview at the				week x 4 weeks, then 2 days a			
	time of observation, the Maintenance Supervisor			week x 4 weeks, then 1 day a				
	agreed the mini fridge was plugged into a power				week x 4 weeks. This will			
	strip.				continue for no less than 3 mo	nths		
	,				and compliance is achieved.			
	This finding was reviewed with the Administrator				and compliance is dollieved.			
	and Maintenance Supervisor at the exit				The Maintenance			
	conference.				Director/Administrator/Designee			
	conference.				will present the results of these			
	3.1-19(b)				audits monthly to the QAPI	-		
	3.1-19(0)				committee for no less than 3			
					months. Any patterns that are	,		
					identified will have an Action F			
					initiated. The QAPI committee			
					determine when 100% compli			
					is achieved or if ongoing	ai iC C		
					monitoring is required.			

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Event ID:

7MYX21 Facility ID: 000493

0493 If

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>01</u> COMPL		COMPLETED	
		155728	B. W	B. WING		04/15/2024	
				CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MANDEDI EV HEALTH CADE CENTED					DD, IN 47037		
MANDERLEY HEALTH CARE CENTER				03600	DD, IN 47037		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
K 0923	NFPA 101						
SS=E	Gas Equipment - 0	Cylinder and Container					
Bldg. 01	Storag						
	Gas Equipment - 0	Cylinder and Container					
	Storage						
	Greater than or eq	ual to 3,000 cubic feet					
	Storage locations	are designed, constructed,					
	and ventilated in a	ccordance with 5.1.3.3.2					
	and 5.1.3.3.3.						
	>300 but <3,000 c	ubic feet					
	Storage locations	are outdoors in an					
	enclosure or within	n an enclosed interior					
	space of non- or li	mited- combustible					
	construction, with	door (or gates outdoors)					
	that can be secure	ed. Oxidizing gases are not					
	stored with flamma	ables, and are separated					
		by 20 feet (5 feet if					
	sprinklered) or enclosed in a cabinet of						
		onstruction having a					
		re protection rating.					
	Less than or equa						
	In a single smoke compartment, individual						
	-	e for immediate use in					
	•	with an aggregate volume					
	•	ual to 300 cubic feet are not					
	required to be stored in an enclosure.						
	-	handled with precautions					
	as specified in 11.						
	•	gn readable from 5 feet is					
	_	ate of a cylinder storage					
		ign includes the wording as					
		TION: OXIDIZING GAS(ES)					
	STORED WITHIN						
		d so cylinders are used in					
		y are received from the					
		ylinders are segregated					
	•	When facility employs					
	•	gral pressure gauge, a					
		e considered empty is					
	established. Emp	ty cylinders are marked to					

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	` ′	A. BUILDING 01		COMPLETED	
		155728		B. WING		— 04/15/2024	
100720				_	ADDRESS STEEL ST. T.	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
MANDERLEY HEALTH CARE CENTER					BUCKEYE ST		
INIAINDEF	LET HEALTH CAR	AL CENTER		USGU	OD, IN 47037		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC	ON
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		Cylinders stored in the open					
	are protected from						
		.3.3, 11.3.4, 11.6.5 (NFPA					
	99)	4.,	K 092	0.00			. .
		on and interview, the facility		923	F923 Gas Equipment-Cylinde	er 05/24/202	24
		inimum distance of at least 20			and Container Storage		
	-	oustible materials from oxygen			1 The facility allegedly faile		
		in 1 of 1 oxygen storage areas.			ensure a minimum distance of	ıaı	
	such as oxygen shall				least 20 feet to separate		
		e of the following: (1) a			combustible material from oxygen storage equipment in 1 of 1		
	_	of 20 feet. (2) a minimum			oxygen storage areas.		
		the required storage location			Janygon storage areas.		
		-			The Maintenance Director		
	is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the				immediately removed combus	tible	
	Installation of Sprinkler Systems. (3) Enclosed				material from the oxygen stora		
	cabinet of noncombustible construction having a				area.		
	minimum fire protection rating of ½ hour. This						
	deficient practice could affect any staff in the				2 The alleged deficient pra	ctice	
liquid oxygen shed.					has the potential to affect any		
					and non were effected in the I		
Findings include:					oxygen shed.		
					The Maintenance Director		
		on during a tour of the facility			completed an audit of the liqui	id	
		ce Supervisor on 04/15/2024			oxygen shed to ensure any		
	between 1:45 PM and 4:00 PM, the facility store				combustible material had been	•	
	liquid oxygen in a metal shed unattached to the				removed. Any identified concerns		
	rest of the building. The shed was not sprinklered. The facility had 4 liquid oxygen containers stored in the shed with a lift and rags, safety glasses, and an apron on a wooden shelf directly over the liquid oxygen containers. The Maintenance Supervisor removed the lift at the time of observation. The Maintenance Director stated he built the shelf to store the rags, safety glasses,				were immediately addressed.	, ,	
					3 The Administrator comple		
					a 1:1 education with the facility		
					Maintenance Director regardir	ıg	
					the requirements to meet		
					NFPA99, NFPA13		
					4 The Maintenance		
	and apron in this lo				Director/Administrator/Designo	ee	
	ap.on in uno 100				will complete rounds to ensure		
	This finding was re	viewed with the Maintenance			combustible material is not	-	
		ninistrator at the exit			present in the liquid oxygen sh	shed	
	conference.				as follows: 3 days a week x 4		
comerciae.							

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l '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/15/2024		
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	(X5) COMPLETION DATE	
	3.1-19(b)				weeks, then 2 days a week x 4 weeks, the 1 day a week x 4 weeks. This will continue for less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designe will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action F initiated. The QAPI committee determine when 100% complia is achieved or if ongoing monitoring is required.	no ee e e Plan will	

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