STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING -- B. WING	02/08/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/08/23 Facility Number: 000493 Provider Number: 155728 AIM Number: 100291300 At this Emergency Preparedness survey, Manderley Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 71 certified beds. At the time of the survey, the census was 42. Quality Review completed on 02/13/23	E 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective March 8, 2023 to the Life Safety / Emergency Preparedness survey completed on February 8th, 2023. We request paper review be completed and the facility will provide any additional information as requested.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/08/23 Facility Number: 000493 Provider Number: 155728 AIM Number: 100291300 At this Life Safety Code survey, Manderley	K 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective March 8,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Estes	HFA, RDO	02/26/2023

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

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	Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V(000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, in all areas open to the corridor and has smoke detectors hard wired to the building electrical system in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 42 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing storage services were sprinklered. The facility has a detached building housing the facility's emergency generator which was fully sprinklered. Quality Review completed on 02/13/23		2023 to the Life Safety / Emergency Preparedness survey completed on February 8th, 2023. We request paper review be completed and the facility will provide any additional information as requested.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of smoke detectors in all resident rooms was	K 0300	1. Smoke detector preventative maintenance documentation was added to the PM logs per regulation. New	03/08/2023

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	complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director from 9:40 a.m. to 12:20 p.m. on 02/08/23, resident sleeping room smoke detector testing and cleaning documentation for the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility does not test or clean the smoke detectors in resident sleeping rooms and agreed an itemized list of resident sleeping room smoke detector testing and cleaning documentation within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, all resident sleeping room smoke detectors are hard wired to the building electrical system and do not report to the building's main fire alarm panel. Manufacturer's documentation affixed to the Kidde Model i12020 smoke detector on the ceiling in Room 206 stated to test the detector weekly and to clean the detector annually. Manufacturer's documentation affixed to the Kidde Model 1235 smoke detector		smoke detectors have been ordered for those smoke detectors that were noted to be more than 10 years from manufacture date. 2. A house-wide visual audit of all resident sleeping room smoke detectors was conducted to ensure all were less than 10 years from manufacture date. 3. Staff in-services were provided to include the Maintenance Director to educate on the preventative maintenance schedule for resident room smoke detectors and that all smoke detectors are to be replaced at least 10 years from manufacture date, per regulation. 4. The Administrator or designee will conduct random audits of smoke detectors to ensure they are not over 10 years from manufacture date, they will also audit the preventative maintenance logs to ensure the smoke detectors are on the preventative maintenance logs appropriately. This tool will be completed monthly times 4 months and then quarterly times 3 quarters. This will be reviewed quarterly in the Quality Assurance Meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality	

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	on the ceiling in Room 209 and Room 314 stated to test the detector weekly and to clean the detector annually. Manufacturer's documentation affixed to the First Alert Model 9020 smoke detector on the ceiling in Room 307 and Room 309 stated to test the detector weekly and to clean the unit monthly. Based on interview at the time of the observations, the Maintenance Director agreed resident sleeping room smoke detector testing and cleaning documentation for the most recent twelve month period was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace smoke alarms installed in 3 of 36 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, all resident sleeping room smoke detectors are hard wired to the building electrical system and do not report to the building's main fire alarm panel. Manufacturer's documentation affixed to the Kidde Model i12020		Assurance Committee.	

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	smoke detector on the ceiling in Room 206 stated the smoke detector was manufactured 01/08/10. Manufacturer's documentation affixed to the Kidde Model 1235 smoke detector on the ceiling in Room 209 and Room 314 stated the smoke detector was manufactured 07/24/06. Based on interview at the time of the observations, the Maintenance Director agreed the three resident sleeping room smoke detectors were more than ten years old. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were	K 0353	1. A letter is attached from vendor stating that since our	03/08/2023

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	provided with the minimum number of spare sprinklers in a spare sprinkler cabinet on the premises for the types and temperature ratings of the sprinklers on the property. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, the spare sprinkler cabinet in the Utility Service room which housed the sprinkler system riser at the south end of the building contained a total of six spare attic type sprinklers. Each spare sprinkler in the cabinet had "200 F" inscribed on the sprinkler. Pendant sprinklers were installed on the ceiling throughout the building in the corridor, all resident sleeping rooms and in the exterior canopies. The pendant sprinkler installed on the ceiling in resident sleeping Room 307 had "155 F" inscribed on the sprinkler. Based on interview at the time of the observations, the Maintenance Director agreed the spare sprinkler cabinet did not contain any spare pendant sprinklers.		sprinkler heads are of a dry system and they are all of different sizes and must be custom made, the facility is not required to keep spare sprinkler heads on hand. An approved plug is available and on hand at the facility in case a sprinkler head should need to be replaced, per regulation and a new plug has been ordered to keep as a spare. 2. All residents have the potential to be affected. 3. Maintenance Director and Administrator were educated regarding the regulation. 4. The Administrator or designee will conduct random audits of sprinkler room to ensure that an approved plug is on hand at all times. This tool will be completed monthly times 4 months and then quarterly times 3 quarters. This will be reviewed quarterly in the Quality Assurance Meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance Committee.	

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	These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC 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 Based on observation and interview, the facility failed to ensure 4 of 4 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 4.3.12.1.1 states egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview at the time of the entrance conference from 9:30 a.m. to 9:40 a.m. on 02/08/23, the Administrator stated the facility applies for an annual LSC waiver for using the corridor as a portion of the return air system/plenum for the facility's HVAC system. The administrator stated	K 0521	1. A request for waiver is being submitted with this plan of correction for this citation. 2. The HVAC system automatically shuts down with the fire alarm system activation.	03/08/2023

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	the HVAC system automatically shuts down with fire alarm system activation. Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, all resident sleeping rooms and all rooms in the south wing were using the egress corridor as a return air system. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters and on third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Maintenance Director	K 0712	1. The times related to fire drills have been revised to assure variance on each of the designated shifts. 2. All residents have the potential to be affected. Fire drills that vary amongst all 3 shifts have been added to the fire drill schedule. 3. Staff in-services were provided to include the	03/08/2023

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	during record review from 9:40 a.m. to 12:20 p.m. on 02/08/23, the following was noted: a. first shift fire drills conducted within the most recent twelve month period on 03/04/22, 06/29/22 and on 12/28/22 were conducted at, respectively, 1:30 p.m., 1:30 p.m. and 1:22 p.m. b. third shift fire drills conducted within the most recent twelve month period on 04/27/22, 07/28/22, 10/27/22 and 01/15/23 were conducted at, respectively, 10:35 p.m., 10:50 p.m., 10:25 p.m. and 10:30 p.m. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed the aforementioned first and third shift fire drills were not conducted at unexpected times under varying conditions. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Maintenance Director to educate on the regulation related to ensuring fire drills are conducted at varying times on all shifts. 4. The Administrator or designee will conduct random audits of fire drills and fire drill logs to ensure they are being conducted at varying times on all shifts. This tool will be completed monthly times 4 months and then quarterly times 3 quarters. This will be reviewed quarterly in the Quality Assurance Meetings to ensure that compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance Committee.	
K 0761 SS=E Bldg. 01	Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were 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,	K 0761	1. The maintenance director has updated the fire door inspection documentation tool to include itemized location of all fire doors to be inspected, along with all testing items per NFPA 80. 2. All fire doors have been inspected, along with all testing items per NFPA 80 and documentation includes itemized location of all fire doors, including the oxygen storage door. 3. Staff in-services were	03/08/2023

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	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: (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. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.		provided to include the Maintenance Director to educate on the regulation related to ensuring proper documentation of itemized location with all testing items included. 4. The Administrator or designee will audit the schedule for fire door inspections to ensure there are itemized locations for all fire doors that are to be inspected, along with testing items per NFPA 80. This will be reviewed quarterly in quality assurance meetings to ensure compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee.	

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	This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Maintenance Annually Checklist" documentation with the Maintenance Director during record review from 9:40 a.m. to 12:20 p.m. on 02/08/23, fire door inspection documentation for the most recent twelve month period was not itemized by location and did not include all applicable inspection and testing items per NFPA 80. The aforementioned checklist documentation stated "check all doors for penetrations through door" and to "check automatic door closures for proper function". Based on interview at the time record review, the Maintenance Director agreed fire door inspection documentation for the most recent twelve month period was not itemized by location and did not include all applicable inspection and testing items per NFPA 80. Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, the corridor door to the oxygen storage room by the Utility Service room at the south end of the facility had a 60-minute fire resistance rating label affixed to the hinge side of the door. Nine 'E' type oxygen cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed fire door inspection documentation did not expressly state the door to the oxygen storage room was included in fire door inspection documentation. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			

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K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 7 of 36 resident sleeping rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and	K 0914	1. The receptacles in resident rooms 104, 106, 203, 206, 207, 208 and 308 have been replaced with hospital grade receptacles. 2. A house wide audit of all resident rooms has been conducted to ensure all receptacles are hospital grade. All receptacles that were found not to be hospital grade have been replaced. 3. The maintenance	03/08/2023

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	155728	A. BUILDING 01 B. WING	02/08/2023

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	so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affects over 10 residents. Findings include: Based on review of "Receptacle Tests-Annual" documentation dated 01/25/22 with the Maintenance Director during record review from 9:40 a.m. to 12:20 p.m. on 02/08/23, select electrical receptacles in resident sleeping Room 104, 106, 203, 206, 207, 208 and 308 failed inspection and testing and were "Replaced" following the 01/25/22 annual testing and inspection. Based on interview at the time of record review, the Maintenance Director stated he replaced receptacles which failed the 01/25/22 annual inspection but the replacement receptacles were not hospital-grade. Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, the receptacle locations which were replaced in the aforementioned seven resident sleeping rooms were not hospital grade. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		department has been educated regarding the regulation stating that hospital grade electrical outlets are present at bedside locations. 4. The Administrator or designee will randomly audit 5 resident bedrooms to ensure they have hospital grade receptacles in place. This tool will be completed monthly times 4 months, then quarterly times 3 quarters. This will be reviewed quarterly in quality assurance meetings to ensure compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and			

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	Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion	K 0920	1. The power strip in room 305 has been removed. 2. A house wide audit has been completed to ensure that no other resident rooms have non approved power cords / strips. 3. Staff in-services were provided to include the Maintenance Director to educate on the importance of using approved power cords per regulation. 4. The Administrator or designee will audit 5 random resident rooms to ensure there are no un-approved power cords in use	03/08/2023

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	of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect two residents, staff and visitors in resident sleeping Room 305. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, a lamp was plugged into a power strip on the floor one foot from the resident bed nearest the window in Room 305. The UL listing of the power strip was 1363A. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used in the patient care vicinity for non-PCREE at the aforementioned location. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		and that all equipment is properly plugged into wall outlets. This tool will be completed monthly time 4 months then quarterly times 3 quarters. This will be reviewed quarterly in quality assurance meetings to ensure compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag			

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	Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA			

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	99) Based on observation and interview, the facility failed to ensure 2 of 2 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over five residents, staff and visitors in the vicinity of the Hair Care room by the smoke barrier door set by Room 101. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:40 p.m. to 2:10 p.m. on 02/08/23, two of two 'E' type oxygen cylinders were freestanding on the floor in the Hair Care room by the smoke barrier door set by Room 101 and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of the observations, the Maintenance Director agreed the two oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart and had them removed from the room. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0923	1. All oxygen E cylinders have been properly stored and secured per regulation. 2. Random audits will be conducted per QA schedule to ensure E cylinders continue to remain secured and are appropriately stored in the oxygen room when not in use. 3. Staff in-services were provided to include the Maintenance Director to educate on the importance of ensuring that all E cylinders are stored and secured per regulation. 4. The Administrator or designee will audit the oxygen storage room, as well as other rooms to ensure all E cylinders are properly stored and secured. This tool will be completed monthly time 4 months then quarterly times 3 quarters. This will be reviewed quarterly in quality assurance meetings to ensure compliance is maintained. This review will be conducted by the Administrator and/or their designee prior to the regularly scheduled QA meeting for the next year. Any concerns will be promptly addressed by the Quality Assurance committee.	03/08/2023