Monica Ogden

PRINTED: 03/04/2025 FORM APPROVED OMB NO. 0938-039

02/28/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155728	A. BUILDING B. WING		COMPLETED 02/12/2025
		100720		_	02/12/2020
NAME OF F	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST	
MANDEF	RLEY HEALTH CAF	RE CENTER		OD, IN 47037	
(X4) ID	SUMMARY	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	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000					
Bldg	An Emergency Pre	paredness Survey was	E 0000	The facility recognizes that it r	nust
		ndiana Department of Health in	L 0000	persuade your office that	nuot
	accordance with 42	-		appropriate systems are in pla	ice
				to assure ongoing compliance	with
	Survey Date: 02/12	2/25		the federal regulations for	
	T 111/2 3.7 1 2	200.402		participation in the Medicare a	nd
	Facility Number: 0 Provider Number:			Medicaid programs. Please	
	AIM Number: 100			accept the following as our process to ensure that the	
	Anvi Number. 100	291300		necessary steps will be taken	to
	At this Emergency	Preparedness survey,		provide the best care possible	
		Care Center was found in		the residents at Manderley	
		nergency Preparedness		Healthcare. Preparation and	
	Requirements for M	Medicare and Medicaid		execution of this plan of corre	ction
		ders and Suppliers, 42 CFR		does not constitute admission	or
	483.73.			agreement by the provider of	:he
	I -	certified beds. At the time of		truth of the facts alleged or	
	the survey, the cens	sus was 52.		conclusions set forth in the	
	Ovality Baylayy age	mulated on 02/19/25		statement of deficiencies. This	5
	Quality Review cor	mpleted on 02/18/25		plan of correction is prepared and/or executed solely because	oo it
				is required by the provisions of	
				federal and state law. Mander	
				Healthcare respectfully reques	· · ·
				consideration of a desk review	
				the alleged deficiencies within	this
				plan of correction. Monica Og	
				HFA	
K 0000					
Bldg. 01					
	1	Recertification and State	K 0000	The facility recognizes that it r	nust
		vas conducted by the Indiana		persuade your office that	
	_	lth in accordance with 42 CFR		appropriate systems are in pla	
	483.90(a).			to assure ongoing compliance	WILL
				the federal regulations for	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	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) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COM		COMPL	ETED	
		155728	B. W	B. WING 02/12/202			/2025
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					BUCKEYE ST		
MANDEF	RLEY HEALTH CAF	RE CENTER		OSGO	OD, IN 47037		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Survey Date: 02/1	2/25			participation in the Medicare a	nd	
					Medicaid programs. Please		
	Facility Number: (000493			accept the following as our		
	Provider Number:				process to ensure that the		
	AIM Number: 100				necessary steps will be taken	to	
					provide the best care possible		
	At this Life Safety	Code survey, Manderley			the residents at Manderley		
	1	r was found not in compliance			Healthcare. Preparation and		
		for Participation in			execution of this plan of correct	ction	
	_	d, 42 CFR Subpart 483.90(a),			does not constitute admission		
		ire and the 2012 Edition of the			agreement by the provider of t		
		ection Association (NFPA) 101,			truth of the facts alleged or		
	Life Safety Code (LSC), Chapter 19, Existing				conclusions set forth in the		
		pancies and 410 IAC 16.2.			statement of deficiencies. This	5	
	·				plan of correction is prepared		
	This one story facil	lity was determined to be of			and/or executed solely because	se it	
	Type V(000) const	ruction and was fully			is required by the provisions o		
	sprinklered. The fa	acility has a fire alarm system			federal and state law. Mander		
	with smoke detecti	on in the corridor, in all areas			Healthcare respectfully reques	-	
	open to the corrido	r and has smoke detectors hard			consideration of a desk review		
	wired to the building	ng electrical system in all			the alleged deficiencies within	this	
	resident sleeping ro	ooms. The facility has a			plan of correction. Monica Ogo		
	capacity of 71 and	had a census of 52 at the time			HFA		
	of this visit.						
	All areas where res	sidents have customary access					
	were sprinklered as	nd all areas providing storage					
	services were sprin	klered. The facility has a					
	detached building l	housing the facility's					
	emergency generat	or which was fully sprinklered.					
	Quality Review con	mpleted on 02/18/25					
K 0271	NFPA 101						
SS=E	Discharge from E	xits					
Bldg. 01							
		on and interview, the facility	K 0	271	K271		03/07/2025
		of over 5 exit discharges was			1 The facility allegedly faile		
		s. LSC 7.7.1(4) requires			ensure 1 of 5 exit discharges v		
	compliance with L	SC 7.1.10. LSC 7.1.10.1 states			not free of all obstructions and	l	

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 02/12/2025
PROVIDER OR SUPPLIER		806 S	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OOD, IN 47037	
SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR that means of egress maintained free of a to full instant use in emergency. This de residents and staff. Findings include: Based on observation tour of the facility we Supervisor (MS) on and 2:30 PM, the experiment of the concrete where the concrete where the met. The MS stated wide and would need wheelchairs and bed evacuating. This finding was resoft discovery and ag		806 S	BUCKEYE ST	ee e e lee for
			will present the results of thes audits monthly and will immediately report if concerns exist and will be discussed du	3

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/12/2025
	ROVIDER OR SUPPLIER		806 S E	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				the QAPI committee for no les than 3 months. Any patterns that are identified will have an Activation Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncomplicate identified through the auditation process. The QAPI committee determine when 100% complicates achieved or if ongoing monitoring is required.	hat on ance ting will
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage				
	failed to ensure 1 of outside of the facility facility exit. LSC 7 passage, or stairway way of exit access a so that it is likely to be identified by a si EXIT. The NO EX in letters 2 inches h 3/8ths inch, and the NO, unless such sig sign. This deficient residents. Findings include: Based on observation tour of the facility was Supervisor (MS) on and 2:30 PM, in the	on and interview, the facility I courtyard doors to the ty were not mistaken as a .10.8.3.1 states any door, that is neither an exit nor a and that is located or arranged be mistaken for an exit shall gn that reads as follows: NO IT sign shall have the word NO igh, with a stroke width of word EXIT below the word in is an approved existing practice could affect 15 ons and interview during a with the Maintenance .02/12/25 between 12:30 PM "Living Room" the door to the as not an exit door and the	K 0293	K293 Exit signage 1 The facility allegedly faile ensure 1 of 1 courtyard door to outside courtyard was not pos with a "no exit" sign. The facility immediately correct the alleged deficient practice by placing a new "No exit sign at courtyard door. 2 The alleged deficient prachas the potential to affect 15 residents and staff. The Maintenance Director completed an audit of all "no eddoors to ensure each had the exit" signs posted. Any found to be in noncompliance was immediately corrected. 3 The regional maintenance.	o the ted cted by the ctice exit" "no

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/12/2025
	PROVIDER OR SUPPLIER		806 S I	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OD, IN 47037	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview observations, the M courtyard is not an acknowledged the c "NO EXIT" sign po This finding was re of discovery and ag	S and AD stated the exit to the public way and ourtyard door did not have a		director completed a 1:1 educe with the Maintenance Director regarding the requirements to meet LSC 7.10.8.3.1. 4 The Maintenance Director/Administrator/Design will complete one day a week rounds to ensure all "no exit" doors have the signage "no e This will continue for no less to 3 months and compliance is achieved. The Maintenance Director/Administrator/Design will present the results of thes audits monthly and will immediately report if concerns exist and will be discussed duthe QAPI committee for no lest than 3 months. Any patterns are identified will have an Act Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncompl are identified through the aud process. The QAPI committee determine when 100% compl is achieved or if ongoing monitoring is required.	r n nee ee se suring ss that ion iance iting e will
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities				
	failed to provide an	on and interview, the facility approved method for ppliances to where they were	K 0324	K324 Cooking facilities 1 The facility allegedly faile have a method of returning 1	

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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	01	COMPLETED	
		155728	B. W	ING		02/12/	2025
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
NAANDEE		NE CENTED			BUCKEYE ST		
MANDER	RLEY HEALTH CAR	RE CENTER		USGUC	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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	when the kitchen ho	ood extinguishing equipment			cooking appliance to where its		
		nstalled for 1 of 1 kitchen hood			kitchen hood extinguishing		
	-	m. NFPA 96 Standard for			equipment was designed and		
		and Fire Protection of			installed.		
		ng Operations Section 2011			The facility immediately correct	cted	
		1.2.2* Cooking appliances			the alleged deficient practice b		
		shall not be moved, modified,			placing tape on the floor so the	-	
		ut prior re-evaluation of the			appliance could be returned to		
	-	ystem by the system installer			approved design location.	7110	
		inless otherwise allowed by			approved design resulten.		
		e extinguishing system.			2 The alleged deficient pra	ctice	
		e fire-extinguishing system			has the potential to affect 0	olioc	
		evaluation where the cooking			residents and 6 staff.		
	-	ed for the purposes of			residents and 0 stair.		
		eaning, provided the			The administrator immediately	,	
		ned to approved design			educated the dietary manager		
		oking operations, and any			along with all dietary associate		
	_	stinguishing system nozzles			along with all dietary associate	5 5.	
		iances are reconnected in			3 The administrator educat	od	
		manufacturer's listed design			the maintenance director on the		
		1.2.3.1 An approved method			NFPA96 section12.1.2.3.1 and		
		at will ensure that the			approved method shall be pro		
	_	d to an approved design			that will ensure appliances is	viueu	
		ient practice affected 6 staff,			returned to an approved design	ınod	
	and no residents.	ient practice affected o staff,			location.	lileu	
	and no residents.				iocation.		
	Findings include:				4 The Maintenance		
	i manigo metade.				Director/Administrator/Designe	20	
	Rased on observation	ons and interview during a			will complete one day a week	J.G	
		vith the Maintenance			rounds to ensure the kitchen		
	-	02/12/25 between 12:30 PM			appliance is retuned to an		
		ix (6) burner gas range and flat			1	النبيد	
	· ·	. ,			approved design location. This		
) which was located on the the hood in the kitchen was			continue for no less than 3 mc	ภเนาร	
					and compliance is achieved.		
	_	n approved method that would			The Medical control		
		iance was returned to an			The Maintenance		
		cation after it had been moved			Director/Administrator/Designe		
		d cleaning. Based on interview			will present the results of thes	е	
		cility was not aware an			audits monthly and will		
	approved method sh	nould be provided to ensure			immediately report if concerns	;	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155728	B. W.		01	02/12/2025	
		100720	J	_		02/12/	2020
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
MANDER	RLEY HEALTH CAR	E CENTER	OSGOOD, IN 47037				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
TAG		ras returned to an approved		IAG	exist and will be discussed du		DATE
		r maintenance or cleaning.			the QAPI committee for no les	•	
					than 3 months. Any patterns t		
		viewed with the MS at the time			are identified will have an Action	on	
		ain during the exit conference nistrator each present.			Plan initiated. Reeducation,		
	with MS and Admin	iistrator each present.			frequency and/or duration of reviews will be increased as		
	3.1-19(b)				needed, if areas of noncomplia	ance	
	, ,				are identified through the audi		
					process. The QAPI committee		
				determine when 100% compliance is achieved or if ongoing monitoring is required.			
					monitoring is required.		
K 0363	NFPA 101						
SS=E Bldg. 01	Corridor - Doors						
-	Based on observation	on and interview, the facility	K 0	363	K363 Corridor Doors		03/07/2025
		Fover 30 corridor doors had no			1 The facility allegedly faile		
	-	ng and latching into the door			have 2 of 30 corridor doors, ea		
		sist the passage of smoke. ice could affect 4 staff.			equipped with self-closing dev		
	Tills deficient practi	ice could affect 4 staff.			failed to self-close and latch in the door frame.	lo	
	Findings include:				The facility immediately corrective alleged deficient practice by		
	Based on observation	ons and interview during a			adjusting both doors, kitchen a	•	
		with the Maintenance			linen so they both latch on the		
	•	02/12/25 between 12:30 PM			door frame.		
	· ·) corridor door to the Kitchen					
	-	nd (2) the Linen Closet on the			2 The alleged deficient practice.	ctice	
		pped with self-closing devices,			has the potential to affect 0		
		and latch positively into the on interview at the time of the			residents and 4 staff.		
		S agreed the aforementioned			An audit was completed on all	30	
		ot close and latch into the			doors to ensure all would latch		
		ald not resist the passage of			into the door frames. Any door		
	smoke.	- -			found not to latch were		
					immediately fixed.		
	This finding was rev	viewed with the MS at the time					

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	OF CORRECTION	IDENTIFICATION NUMBER 155728	A. BUILDING B. WING	01	COMPLETED 02/12/2025
	PROVIDER OR SUPPLIER		806 S E	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		ain during the exit conference aistrator each present.		3 The administrator educat the maintenance director on N 101 Corridor Doors.	
				4 The Maintenance Director/Administrator/Designe will complete one day a week rounds to ensure all 30 doors in compliance. This will contine for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designe will present the results of thes audits monthly and will immediately report if concerns exist and will be discussed du the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncomplia are identified through the audit process. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required.	are ue ee er ring is that on ance ting e will
K 0521 SS=F Bldg. 01	NFPA 101 HVAC				
3143	failed to ensure 1 of used as a portion of heating, ventilating,	n and interview, the facility 4 egress corridors were not a return air system/plenum for or air conditioning (HVAC) ljoining areas. LSC 19.5.2.1	K 0521	K521 HVAC 1 The facility allegedly faile ensure 4 of 4 egress corridors were not used as a portion of a	i

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155728		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/12/2025	
	PROVIDER OR SUPPLIER		806	ET ADDRESS, CITY, STATE, ZIP COD S BUCKEYE ST GOOD, IN 47037	
	SUMMARY SUMMARY SEACH DEFICIEN REGULATORY OR requires air condition ductwork and relate accordance with NF Installation of Air C Systems. NFPA 90 4.3.12.1.1 states egras a portion of a sur system serving adjopermitted by 4.3.12 deficient practice coand visitors. Findings include: Based on interview 02/12/25 between 1 the Maintenance Su Administrator (AD) typically receives a dampers and the system system activate with the Maintenance the facility, all residerooms in the south we south the south of the sou	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION oning, heating, ventilating d equipment to be installed in PA 90A, Standard for the conditioning and Ventilating A, 2012 Edition, Section ress corridors shall not be used oply, return, or exhaust air ining areas unless otherwise 1.3.1 through 4.3.12.1.3.4. This ould affect all residents, staff during record review on 0:25 AM and 12:30 PM, with pervisor (MS) and it was stated the facility waiver for the fire/smoke stem shuts down with fire tion. Based on observations the Supervisor during a tour of tent sleeping rooms and all wing were using the egress	806	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY) return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwo serving adjoining areas. The facility immediately renother Life Safety Code Waive 2. The alleged deficient phas the potential to affect all residents, staff and visitors. The facility immediately renother Life Safety Code Waive Request. 3. The Administrator comma 1:1 education with the Maintenance Director regard the requirements to meet NFPA90A and LSC 19.4.2.1 4. The Maintenance Director/Administrator/Designal will validate Life Safety Code Waiver is in place and not expert to the requirement of the control	ERRATE COMPLETION DATE DATE Ork ewed er. ractice ewed er pleted ding gnee e xpired
		e reviewed with the the Maintenance Supervisor at y and again during the exit		weekly for 12 weeks. This continue for no less than 3 rand compliance is achieved. The Maintenance Director/Administrator/Designed will present the results of the audits monthly to the QAPI committee for no less than 3 months. Any patterns that a identified will have an Action initiated. The QAPI committed determine when 100% complis achieved or if ongoing monitoring is required.	months . gnee ese 3 are n Plan ee will

X7X421

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 02/12/2025
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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record reversely failed to conduct quality unexpected days and varying conditions, affect all residents, affect all residen	riew and interview, the facility arterly fire drills on d at unexpected times under This deficient practice could staff and visitors in the facility. during record review on 0:25 AM and 12:30 PM, with pervisor (MS) and 8 of 12 quarterly fire drills r the end of the month, d 30th day of the month. The not allow fire drills to be sected and unpredictable ereviewed with the he Maintenance Supervisor at y and again during the exit	K 0712	K712 Fire Drills 1 The facility allegedly faile ensure fire drills were held at unexpected times as 8 of 12 fi drills were held near the end of month. The dates related to fire drills been revised to assure variance each of the designated shifts. 2 The alleged deficient prachas the potential to affect all residents and staff. Fire drills that vary amongst all shifts have been added to the drill schedule. 3 The administrator complete a 1:1 education with the Maintenance Director regarding the requirements to meet NFP 101 19.7.1. 4 Administrator/Designee we conduct random audits of fire of and fire drill logs to ensure the are being conducted at varying dates on all shifts. This tool will completed monthly for no less than 3 months and compliance achieved. The Maintenance Director/Administrator/Designer will present the results of these audits monthly and will	o3/07/2025 d to re if the have be on ctice I 3 fire eted ag A will drills by g II be e is

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/12/2025
	ROVIDER OR SUPPLIER		806 S	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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulation Based on observation interview, the facility non-smoking policic could affect 15 residual forms include: Based on observation tour of the facility understanding to the facility understanding to the facility of the facility of the facility of the facility of the facility was one of the facility of the faci	on, records review, and ty failed enforcement 1 of 1 es. This deficient practice dents and staff. ons and interview during a upon arrival on 02/12/25 at g on the property was observed the door to the courtyard The aforementioned location ity's two designated smoking smoking policy stated that lowed within 8 feet of the with State Law. At the time surveyor asked staff in the wo women who were smoking	K 0741	immediately report if concerns exist and will be discussed du the QAPI committee for no less than 3 months. Any patterns are identified will have an Acti Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncompli are identified through the audi process. The QAPI committee determine when 100% compli is achieved or if ongoing monitoring is required. K741 1 The facility allegedly failed ensure smoking did not happed within 8 feet of the building. The facility immediately correct the alleged deficient practice the ensuring no one smokes within feet of the building. The nonsmoking area was marked 8 feet to ensure compliance. 2 The alleged deficient practice the facility immediately correct the alleged deficient practice the ensuring no one smokes within feet of the building. The	ring ss that on ance ting e will ance oted by n 8 l our ctice oted by n 9 l our ctice oted by n 9 l our ctice oted by n 9 l ou
	_	e the door to the living room and it was confirmed that they		nonsmoking area was marked 8 feet to ensure compliance.	i oui

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 02/12/2025
	PROVIDER OR SUPPLIER		806 S	ADDRESS, CITY, STATE, ZIP COD BUCKEYE ST OOD, 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 APPROPRI/	(X5) COMPLETION DATE
	of discovery and ag	viewed with the MS at the time ain during the exit conference nistrator each present.		3 The administrator/design completed a 1:1 education with the staff regarding NFPA 18.7.4,19.7.4 smoking. 4 The Maintenance Director/Administrator/Design will complete one day a week rounds to ensure no one smowithin 8 feet of the building. The Maintenance Director/Administrator/Design will present the results of the audits monthly and will immediately report if concerns exist and will be discussed duthe QAPI committee for no lest than 3 months. Any patterns are identified will have an Act Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncompliare identified through the aud process. The QAPI committee determine when 100% complisis achieved or if ongoing monitoring is required.	ee kes ee se suring ss that ion ance iting e will
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure 1 or properly and used in Section 10.2.4.2 sta	on and interview, the facility of 1 flexible cords were installed on a safe manor. NFPA 99, tes adapters and extension equirements of 10.2.4.2.1	K 0920	K920 Electrical Equipment-Power Cords and Extensions 1 The facility allegedly faile ensure 1 power strip in room	ed to

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		01	COMPLETED	
		155728	B. WING			02/12/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			BUCKEYE ST		
 MANDER	RLEY HEALTH CAI	RE CENTER			OD, IN 47037		
					1		T
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORE			(X5)
PREFIX	, and the second	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	_	shall be permitted. Section		was not secured and dang			
		e cabling shall comply with			from the wall behind the TV.		
	10.2.3. Section 10.2.3.5.1 states cord strain relief				The Maintenance Director		
	shall be provided at the attachment of the power				immediately tacked up the pov	wer	
	cord to the appliance so that mechanical stress,			strip in room 304.			
	either pull, twist, or bend, is not transmitted to				-	alleged deficient practice	
		ns. This deficient practice could		has the potential to affect			
	affect 2 residents.			residents, staff and vis			
					The Maintenance Director		
	Findings include:				1 · · · · · · · · · · · · · · · · · · ·	ompleted an audit to ensure that	
					all power strips were tacked up		
	Based on observations and interview during a				and no cords were dangling.	Any	
	tour of the facility with the Maintenance				identified concerns were		
	Supervisor (MS) on 02/12/25 between 12:30 PM			immediately addressed		-4 - J	
	and 2:30 PM, in Resident Room #304 a power strip			3 The Administrator compl			
	used to power the TV was not secured and				a 1:1 education with the facility	•	
	dangling from the wall behind the TV. This				Maintenance Director regardir	-	
	condition could put stress on the power cord				the requirements to meet NFF	'A	
	causing damage to the power cord. Based on interview at the time of observations, the				section 10.2.4.2.3.		
		etor agreed the power strip was			4 The Maintenance		
					4 The Maintenance	20	
	dangling, not secured, and stated they generally zip tie the power strips to the mounting arm of the				Director/Administrator/Designee will complete rounds to ensure		
	TV's.			power strips are not danglin		7	
	1 v s.				Complete 1 x per week and th	ic	
	This finding was re	eviewed with the MS at the time			will continue for no less than 3		
	_	gain during the exit conference			months and compliance is	,	
	1	inistrator each present.			achieved.		
	with M5 the right	mistrator each present.			acineved.		
	3.1-19(b)						
	3.1 15(0)				The Maintenance		
					Director/Administrator/Designe	ee	
					will present the results of thes		
					audits monthly and will	-	
					immediately report if concerns	;	
					exist and will be discussed du		
					the QAPI committee for no les	-	
					than 3 months. Any patterns to		
					are identified will have an Acti		
					Plan initiated. Reeducation,		

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/12/2025	
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	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
					frequency and/or duration of reviews will be increased as needed, if areas of noncomplia are identified through the audit process. The QAPI committee determine when 100% complia is achieved or if ongoing monitoring is required.	ing will	
K 0921 SS=F Bldg. 01	interview, the facilit required maintenand documentation of in Related Electrical E 2012 edition, section physical integrity, retouch current tests for is performed as requare established with PCREE used in patinaccordance with 10 into service and after Any system consists appliances demonst 99 as a complete symmetric including 10.5.3.1.1 and are coff a program for electrical equipment manuals are readily and condensed oper appliance are legible equipment tests, representations.	eview, observation, and ty failed to conduct the ce and maintain complete aspections for Patient Care Equipment (PCREE). NFPA 99 and 10.3 and 10.5 states the esistance, leakage current, and for fixed and portable PCREE cuired in 10.3. Testing intervals apolicies and protocols. All itent care rooms is tested in a compliance with NFPA stem. Service manuals, poedures provided by the de information as required by considered in the development extrical equipment maintenance. In the transition of the extra and maintenance available, and safety labels rating instructions on the extra and modifications is	K 0	921	K921 Electric equipment maintenance 1 The facility allegedly faile conduct the required maintenance and maintain complete documentation of inspections of Patient Care Related Electrica Equipment. Immediately manuwere gathered for the PCREE inspections began. 2 The alleged deficient prachas the potential to affect all residents. 3 The regional maintenance director educated the maintenadirector on the allegedly praction The inspection requirements wadded to Tels to auto generate ensure the inspections are completed and documented accordingly.	for l als and ctice e ance ce.	03/07/2025
		riod of time to demonstrate			4 The Maintenance		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155728	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/12/2025		
NAME OF PROVIDER OR SUPPLIER MANDERLEY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 806 S BUCKEYE ST OSGOOD, IN 47037				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDERIC DI ANI OF CORRECTIONI	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	compliance in accordance with the facility's				Director/Administrator/Designee		
	policy. Personnel re	esponsible for the testing,			will monitor to ensure all new or		
	maintenance and use of electrical appliances				after any repair or modifications		
	receive continuous	training. This deficient			are made to PCREE is inspected		
	practice affects all 1	residents.			and documented. This will		
					continue for no less than 3 months		
	Findings include:				and compliance is achieved.		
	Based on interviews during record review on 02/12/25 between 10:25 AM and 12:30 PM, with the Maintenance Supervisor (MS) and Administrator (AD) no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The AD stated that PCREE such as nebulizers, oxygen concentrators, resident beds, and other electrical medical equipment was present and in use at the facility. Both MS and AD stated that the facility was not aware that the PCREE was required to be tested. This finding was reviewed with the MS at the time of discovery and again during the exit conference with MS and Administrator each present.				The Maintenance Director/Administrator/Designation will present the results of thes audits monthly and will immediately report if concerns exist and will be discussed du the QAPI committee for no lest than 3 months. Any patterns are identified will have an Acti Plan initiated. Reeducation, frequency and/or duration of reviews will be increased as needed, if areas of noncompli are identified through the audi process. The QAPI committee determine when 100% compli is achieved or if ongoing monitoring is required.		
	3.1-19(b)						