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	02/12/2025

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: 02/12/25 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 52. Quality Review completed on 02/18/25	E 0000	The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps 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 facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk review for the alleged deficiencies within this plan of correction. Monica Ogden HFA	
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).	K 0000	The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Monica Ogden	LHFA	02/28/2025

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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	Survey Date: 02/12/25 Facility Number: 000493 Provider Number: 155728 AIM Number: 100291300 At this Life Safety Code survey, Manderley Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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 52 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 02/18/25		participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps 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 facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk review for the alleged deficiencies within this plan of correction. Monica Ogden HFA	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of over 5 exit discharges was free of obstructions. LSC 7.7.1(4) requires compliance with LSC 7.1.10. LSC 7.1.10.1 states	K 0271	**K271** 1 The facility allegedly failed to ensure 1 of 5 exit discharges was not free of all obstructions and	03/07/2025

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	that means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect 8 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) on 02/12/25 between 12:30 PM and 2:30 PM, the exit discharge from the 200 Hall near Resident Room #211, had a significant gap in the concrete where the landing and the sidewalk met. The MS stated that the gap was 2 to 3 inches wide and would need to be filled with concrete, so wheelchairs and beds didn't get stuck in the gap if evacuating. This finding was reviewed with the MS at the time of discovery and again during the exit conference with MS and Administrator each present. 3.1-19(b)		impediments. The exit discharge from hall 200 had a significant gap in the concrete where the landing and sidewalk meet. The facility immediately corrected the alleged deficient practice by filing in the gap. 2 The alleged deficient practice has the potential to affect 8 residents and staff. The Maintenance Director completed an audit on the other 4 exits to ensure all were free from obstructions and impediments. Any findings were immediately corrected. 3 The administrator completed a 1:1 education with the Maintenance Director regarding the requirements to meet LSC 7.10.8.3.1. 4 The Maintenance Director/Administrator/Designee will complete one day a week rounds to ensure all 5 exits are free from obstructions and impediments. 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 and will immediately report if concerns exist and will be discussed during	

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			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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) on 02/12/25 between 12:30 PM and 2:30 PM, in the "Living Room" the door to the outside courtyard was not an exit door and the	K 0293	**K293 Exit signage** 1 The facility allegedly failed to ensure 1 of 1 courtyard door to the outside courtyard was not posted with a “no exit” sign. The facility immediately corrected the alleged deficient practice by placing a new “No exit sign at the courtyard door. 2 The alleged deficient practice has the potential to affect 15 residents and staff. The Maintenance Director completed an audit of all “no exit” doors to ensure each had the “no exit” signs posted. Any found to be in noncompliance was immediately corrected. 3 The regional maintenance	03/07/2025

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	door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the MS and AD stated the courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" sign posted. This finding was reviewed with the MS at the time of discovery and again during the exit conference with MS and Administrator each present. 3.1-19(b)		director completed a 1:1 education with the Maintenance Director regarding the requirements to meet LSC 7.10.8.3.1. 4 The Maintenance Director/Administrator/Designee will complete one day a week rounds to ensure all “no exit” doors have the signage “no exit”. 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 and will immediately report if concerns exist and will be discussed during 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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were	K 0324	**K324 Cooking facilities** 1 The facility allegedly failed to have a method of returning 1 of 1	03/07/2025

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	when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6 staff, and no residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) on 02/12/25 between 12:30 PM and 2:30 PM, the six (6) burner gas range and flat grill (one appliance) which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the MS, the facility was not aware an approved method should be provided to ensure		cooking appliance to where its kitchen hood extinguishing equipment was designed and installed. The facility immediately corrected the alleged deficient practice by placing tape on the floor so the appliance could be returned to its approved design location. 2 The alleged deficient practice has the potential to affect 0 residents and 6 staff. The administrator immediately educated the dietary manager along with all dietary associates. 3 The administrator educated the maintenance director on the NFPA96 section12.1.2.3.1 and the approved method shall be provided that will ensure appliances is returned to an approved designed location. 4 The Maintenance Director/Administrator/Designee will complete one day a week rounds to ensure the kitchen appliance is retuned to an approved design location. 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 and will immediately report if concerns	

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	that the appliance was returned to an approved design location after maintenance or cleaning. This finding was reviewed with the MS at the time of discovery and again during the exit conference with MS and Administrator each present. 3.1-19(b)		exist and will be discussed during 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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 4 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) on 02/12/25 between 12:30 PM and 2:30 PM, the (1) corridor door to the Kitchen marked "Dietary" and (2) the Linen Closet on the 100 Hall, each equipped with self-closing devices, failed to self-close and latch positively into the door frame. Based on interview at the time of the observations, the MS agreed the aforementioned corridor doors did not close and latch into the door frame and would not resist the passage of smoke. This finding was reviewed with the MS at the time	K 0363	**K363 Corridor Doors** 1 The facility allegedly failed to have 2 of 30 corridor doors, each equipped with self-closing devices failed to self-close and latch into the door frame. The facility immediately corrected the alleged deficient practice by adjusting both doors, kitchen and linen so they both latch on the door frame. 2 The alleged deficient practice has the potential to affect 0 residents and 4 staff. An audit was completed on all 30 doors to ensure all would latch into the door frames. Any doors found not to latch were immediately fixed.	03/07/2025

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	of discovery and again during the exit conference with MS and Administrator each present. 3.1-19(b)		3 The administrator educated the maintenance director on NFPA 101 Corridor Doors. 4 The Maintenance Director/Administrator/Designee will complete one day a week rounds to ensure all 30 doors are in compliance. 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 and will immediately report if concerns exist and will be discussed during 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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure 1 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	K 0521	**K521 HVAC** 1 The facility allegedly failed to ensure 4 of 4 egress corridors were not used as a portion of a	03/07/2025

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	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 during record review on 02/12/25 between 10:25 AM and 12:30 PM, with the Maintenance Supervisor (MS) and Administrator (AD) it was stated the facility typically receives a 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, 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 Supervisor at the time of discovery and again during the exit conference with each present. 3.1-19(b)		return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. The facility immediately renewed their Life Safety Code Waiver. 2 The alleged deficient practice has the potential to affect all residents, staff and visitors. The facility immediately renewed their Life Safety Code Waiver Request. 3 The Administrator completed a 1:1 education with the Maintenance Director regarding the requirements to meet NFPA90A and LSC 19.4.2.1 4 The Maintenance Director/Administrator/Designee will validate Life Safety Code Waiver is in place and not expired weekly for 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.	

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K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on interview during record review on 02/12/25 between 10:25 AM and 12:30 PM, with the Maintenance Supervisor (MS) and Administrator (AD) 8 of 12 quarterly fire drills were conducted near the end of the month, between the 27th and 30th day of the month. These conditions do not allow fire drills to be conducted on unexpected and unpredictable days. These findings were reviewed with the Administrator and the Maintenance Supervisor at the time of discovery and again during the exit conference with each present. 3.1-19(b) 3.1-51(c)	K 0712	**K712 Fire Drills** 1 The facility allegedly failed to ensure fire drills were held at unexpected times as 8 of 12 fire drills were held near the end of the month. The dates related to fire drills have been revised to assure variance on each of the designated shifts. 2 The alleged deficient practice has the potential to affect all residents and staff. Fire drills that vary amongst all 3 shifts have been added to the fire drill schedule. 3 The administrator completed a 1:1 education with the Maintenance Director regarding the requirements to meet NFPA 101 19.7.1. 4 Administrator/Designee will conduct random audits of fire drills and fire drill logs to ensure they are being conducted at varying dates on all shifts. This tool will be completed monthly for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly and will	03/07/2025

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			immediately report if concerns exist and will be discussed during 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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation, records review, and interview, the facility failed enforcement 1 of 1 non-smoking policies. This deficient practice could affect 15 residents and staff. Findings include: Based on observations and interview during a tour of the facility upon arrival on 02/12/25 at 10:10 AM, smoking on the property was observed immediately outside the door to the courtyard 'Living Room" exit. The aforementioned location was one of the facility's two designated smoking areas. The provided smoking policy stated that smoking was not allowed within 8 feet of the building, consistent with State Law. At the time of observation, the surveyor asked staff in the living room if the two women who were smoking immediately outside the door to the living room were facility staff and it was confirmed that they were.	K 0741	**K741** 1 The facility allegedly failed to ensure smoking did not happen within 8 feet of the building. The facility immediately corrected the alleged deficient practice by ensuring no one smokes within 8 feet of the building. The nonsmoking area was marked our 8 feet to ensure compliance. 2 The alleged deficient practice has the potential to affect 15 residents and staff. The facility immediately corrected the alleged deficient practice by ensuring no one smokes within 8 feet of the building. The nonsmoking area was marked our 8 feet to ensure compliance.	03/07/2025

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	This finding was reviewed with the MS at the time of discovery and again during the exit conference with MS and Administrator each present. 3.1-19(b)		3 The administrator/designee completed a 1:1 education with the staff regarding NFPA 18.7.4,19.7.4 smoking. 4 The Maintenance Director/Administrator/Designee will complete one day a week rounds to ensure no one smokes within 8 feet of the building. The Maintenance Director/Administrator/Designee will present the results of these audits monthly and will immediately report if concerns exist and will be discussed during 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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1	K 0920	**K920 Electrical Equipment-Power Cords and Extensions** 1 The facility allegedly failed to ensure 1 power strip in room 304	03/07/2025

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(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
	through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Supervisor (MS) on 02/12/25 between 12:30 PM and 2:30 PM, in Resident Room #304 a power strip used to power the TV was not secured and dangling from the wall behind the TV. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated they generally zip tie the power strips to the mounting arm of the TV's. This finding was reviewed with the MS at the time of discovery and again during the exit conference with MS and Administrator each present. 3.1-19(b)		was not secured and dangling from the wall behind the TV. The Maintenance Director immediately tacked up the power strip in room 304. 2 The alleged deficient practice has the potential to affect residents, staff and visitors. The Maintenance Director completed an audit to ensure that all power strips were tacked up and no cords were dangling. Any identified concerns were immediately addressed. 3 The Administrator completed a 1:1 education with the facility Maintenance Director regarding the requirements to meet NFPA section 10.2.4.2.3. 4 The Maintenance Director/Administrator/Designee will complete rounds to ensure power strips are not dangling: Complete 1 x per week and 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 and will immediately report if concerns exist and will be discussed during the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. Reeducation,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING 01 B. WING	02/12/2025

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			frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate	K 0921	**K921 Electric equipment maintenance** 1 The facility allegedly failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment. Immediately manuals were gathered for the PCREE and inspections began. 2 The alleged deficient practice has the potential to affect all residents. 3 The regional maintenance director educated the maintenance director on the allegedly practice. The inspection requirements were added to Tels to auto generate to ensure the inspections are completed and documented accordingly. 4 The Maintenance	03/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING 01 B. WING	02/12/2025

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	compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: 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. 3.1-19(b)		Director/Administrator/Designee will monitor to ensure all new or after any repair or modifications are made to PCREE is inspected and documented. 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 and will immediately report if concerns exist and will be discussed during 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 noncompliance are identified through the auditing process. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	