

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/18/2015
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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/18/15</p> <p>Facility Number: 012534 Provider Number: 155792 AIM Number: 201028420</p> <p>At this Life Safety Code survey, Countryside Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 171 and had</p>	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Certification Review desk review in lieu of post survey revisit on or after December 18, 2015.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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K 0056 SS=D Bldg. 01	<p>a census of 143 at the time of this visit.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>Quality Review completed on 11/20/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to ensure the sprinkler system was installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 5-6.4.1.1 states the distance between pendent sprinkler deflectors and the ceiling shall be a minimum of one inch and a maximum of twelve inches. This deficient practice could affect 5 residents, staff and visitors</p>	K 0056	<b>K-056</b> The facility must have an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the installation of Sprinkler Systems, with approved components, devices, and equipment to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, testing, and maintenance of the	12/18/2015

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	<p>in the vicinity of main entrance canopy.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 11/18/15, the pendent sprinkler deflector for one of nine automatic sprinkler locations under the front entrance canopy was aligned in the plane of the canopy ceiling inside a hole where an escutcheon plate was missing. Based on interview at the time of observation, the Maintenance Director acknowledged the deflector for the aforementioned sprinkler head was not aligned properly under the front entrance canopy.</p> <p>3.1-19(b) 3.1-19(ff)</p>		<p>water-based fire protections systems. There is a reliable, adequate water supply for the system. The system is equipped with water flow and tamper switches which are connected to the fire alarm system. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>·A new dry pendant for the canopy was ordered by Dalmation Fire, Inc on 11/25/15.</li> </ul> <p><b>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·A new dry pendant for the canopy was ordered by Dalmation Fire, Inc on 11/25/15.</li> <li>·Dalmation will install the new drypendant once it has arrived.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur:</b></p> <ul style="list-style-type: none"> <li>·The Maintenance Director/designee will inspect the canopy pendants weekly.</li> </ul> <p><b>How corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put</b></p>		

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K 0062 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 2 of over 100 sprinkler heads was maintained. NFPA 13, Standard for the Installation of Sprinkler Systems, Section 3-2.7.2 states escutcheon plates used with a recessed or flush-type sprinkler shall be part of a listed sprinkler assembly. This deficient practice could affect 5 residents, staff and visitors in the vicinity of main entrance canopy.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 11/18/15, the escutcheon plate was</p>	K 0062	<p><b>into place and</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director/designee will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and Medical Director. If threshold of 95% is not achieved an action plan will be developed.</li> </ul> <p><b>K-062</b> The facility is required to have automatic sprinkler systems that are continuously maintained in reliable operating condition and are inspected and tested periodically. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <ul style="list-style-type: none"> <li>The 2 escutcheon plates for the canopy were ordered by Dalmation Fire, Inc on 11/25/15.</li> </ul> <p><b>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>All residents have the potential to be affected by the alleged deficient practice.</li> <li>The 2 escutcheon plates for</li> </ul>	12/18/2015

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K 0066 SS=D Bldg. 01	<p>missing for two of nine automatic sprinkler locations under the front entrance canopy. Based on interview at the time of the observations, the Director of Maintenance acknowledged the escutcheon plate for the aforementioned two automatic sprinkler locations was missing.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read</p>		<p>the canopy were ordered by Dalmation Fire, Inc on 11/25/15.</p> <ul style="list-style-type: none"> <li>·Dalmation will install the escutcheon plates will be installed once they have arrived.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur:</b></p> <ul style="list-style-type: none"> <li>·The Maintenance Director/designee will inspect the canopy escutcheon plates weekly.</li> </ul> <p><b>How corrective action(s) will be monitored to ensure the deficient practice willnot recur; i.e. what quality assurance program will be put into place and it will be monitored</b></p> <ul style="list-style-type: none"> <li>·The Maintenance Director/designee will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and Medical Director. If threshold of 95% is not achieved an action plan will be developed.</li> </ul>				

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	<p>NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container with a self closing lid at 2 of 2 outside areas where smoking was permitted. This deficient practice could affect 2 staff and visitors in the vicinity of the service hall exit and the kitchen exit on the northwest side of the facility.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 11/18/15, the staff smoking area located outside the building at the service hall exit and the kitchen exit on the northwest side of the facility each had in excess of 50 extinguished cigarette butts deposited on the ground. A noncombustible container with a self closing cover device</p>	K 0066	<p><b>K-066</b> Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. Smoking by patients classified as not responsible is prohibited, except when under direct supervision. Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>·A non-combustible container</p>	12/18/2015

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	<p>into which cigarette butts can be deposited was not provided for either of these two areas where staff smoking was permitted. Based on interview at the time of the observations, the Maintenance Director acknowledged a metal container with a self closing cover device into which ashtrays can be emptied was not provided at each of the two aforementioned outside smoking areas.</p> <p>3.1-19(b)</p>		<p>for cigarette butts was placed outside the staff entrance and kitchen entrance on11/25/15 by the Maintenance Director. <b>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> ·All residents have the potential to be affected by the alleged deficient practice. ·A non-combustible container for cigarette butts was placed outside the staff entrance and kitchen entrance on11/25/15 by the Maintenance Director. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur:</b> ·A non-combustible container for cigarette butts was placed outside the staff entrance and kitchen entrance on11/25/15 by the Maintenance Director. ·The Maintenance Director/designee will tour the outside of the facility weekly to ensure the non-combustible containers are in place. <b>How corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place and</b> ·The Maintenance Director/designee will complete the Life Safety Review CQI</p>		

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K 0067 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A</p> <p>Based on record review, observation and interview; the facility failed to ensure 4 of 266 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork (HVAC) and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3-4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. NFPA 90A, at 2-3.4.1 states a service opening shall be provided in air ducts adjacent to each fire</p>	K 0067	<p>weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and Medical Director. If threshold of 95% is not achieved an action plan will be developed.</p> <p><b>K-067</b> Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> ·The four fire dampers were inspected and replaced by Chapman on 11/30/15. <b>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> ·All residents have the potential to be affected by the alleged deficient practice. ·The four fire dampers were inspected and replaced by Chapman on 11/30/15. <b>What measures will be put into place or what systemic</b></p>	12/18/2015	

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	<p>damper. The opening shall be large enough to permit maintenance and resetting of the device. This deficient practice could affect 50 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Service "Inspection Form &amp; Reports" documentation dated September 2015 with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/18/15, documentation of fire damper inspection and maintenance within the most recent four year period for four fire damper locations stated "visual only". The four locations identified in the aforementioned documentation are "100 Sitting Mech Room", "300 Hall Laundry Mech Room", "400 Hall Laundry Mech Room" and "Outside Room 522". In addition, the fire damper location identified as "100 Sitting Mech Room" also stated "unable to reach to change link". Based on interview at the time of record review, the Maintenance Director stated no additional fire damper inspection and maintenance documentation was available for review and acknowledged documentation of the necessary maintenance and inspection for the aforementioned four fire dampers in the</p>		<p><b>changes will be made to ensure that the deficient practice does not occur:</b></p> <ul style="list-style-type: none"> <li>All fire dampers will be inspected every four years and replaced in 2019. The completed work ticket will be reviewed by the Maintenance Director/designee to ensure that each damper has been inspected and replaced.</li> </ul> <p><b>How corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place and</b></p> <ul style="list-style-type: none"> <li>The Maintenance Director/designee will complete the Life Safety Review CQI weekly x 4 weeks then monthly times 6 and quarterly thereafter for one year. The results of this audit will be reviewed by CQI committee overseen by ED and Medical Director. If threshold of 95% is not achieved an action plan will be developed.</li> </ul>				

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K 0144 SS=F Bldg. 01	<p>facility within the most recent four year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:45 a.m. to 1:50 p.m. on 11/18/15, fire dampers were located throughout the facility including the aforementioned four locations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 4 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability</p>	K 0144	<p><b>K-144</b> Generators are inspected weekly and exercised under load tests for 30 minutes per month in accordance with NFPA 99. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> ·The transfer switch time for the generator was adjusted from 15</p>	12/18/2015

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	<p>requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Exercise/Monthly Generator Test" documentation with the Maintenance Director during record review from 9:15 a.m. to 11:45 a.m. on 11/18/15, monthly load test documentation for 08/11/15, 09/08/15, 10/15/15 and 11/10/15 lists the transfer time as 15 seconds. Based on interview at the time of record review, the Maintenance Director stated a new generator was installed in July 2015 which replaced the former generator and acknowledged it took greater than ten seconds to transfer power to the emergency generator for the most recent four monthly load tests.</p> <p>3.1-19(b)</p>		<p>seconds to 8 seconds by Vanguard on 11/19/15.</p> <p><b>How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <ul style="list-style-type: none"> <li>·All residents have the potential to be affected by the alleged deficient practice.</li> <li>·The transfer switch time for the generator was adjusted from 15 seconds to 8 seconds by Vanguard on 11/19/15.</li> </ul> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur:</b></p> <ul style="list-style-type: none"> <li>·The transfer switch time for the generator was adjusted from 15 seconds to 8 seconds by Vanguard on 11/19/15.</li> <li>·The Maintenance Director/designee will complete the generator load test monthly and document the time for each test.</li> <li>·If a variation in time greater than 10 seconds is noted the Maintenance Director/designee will contact the generator service provider and request service to repair.</li> </ul> <p><b>How corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e. what quality assurance program will be put into place and</b></p> <ul style="list-style-type: none"> <li>·The Maintenance Director/designee will complete</li> </ul>				

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