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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155258 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>11/24/2014 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE<br>205 MARINE DR<br>ANDERSON, IN 46016 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| K010000            | <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: 11/24/14</p> <p>Facility Number: 000160<br/>Provider Number: 155258<br/>AIM Number: 100267190</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Countryside Manor Health &amp; Living Community LLC 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 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors with battery operated smoke detectors in</p> | K010000       |                                                                                                                 |                      |

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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| K010061<br>SS=F    | <p>all resident sleeping rooms. The facility has a capacity of 109 and had a census of 100 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility has one garage used for facility storage and a shed which houses the generator and both were not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 12/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed.<br/>NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was continuously maintained in reliable operating condition. LSC 9.7.2.1 requires automatic sprinkler systems shall be installed and monitored for integrity and a distinctive supervisory signal shall be provided to indicate a condition which would impair the satisfactory operation of the sprinkler system. Monitoring shall</p> | K010061       | <p>This plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Countryside Manor Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor</p> | 12/09/2014           |

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| NAME OF PROVIDER OR SUPPLIER<br><br>COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>205 MARINE DR<br>ANDERSON, IN 46016                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                             |
| (X4) ID PREFIX TAG                                                              | SUMMARY STATEMENT OF DEFICIENCIES (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 |                                             |
|                                                                                 | <p>include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure and air pressure on dry pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building which is constantly attended by qualified personnel or a an approved, remotely located receiving facility. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observation on 11/24/14 at 1:37 p.m. with the Maintenance Supervisor, the main sprinkler shut off valve for the sprinkler riser located in the mechanical room on Service hall had a chain connected to the main shut off which was padlocked but did not have an electrically supervised tamper switch on the main valve to monitor the integrity of the system. Based on interview on 11/24/14 at 1:38 p.m. with the Maintenance Supervisor, it was acknowledged the facility did not know about the need for electrically supervised tamper switches on sprinkler valves.</p> <p>3.1-19(b)</p> |                                                                 | <p>does this submission constitute an agreement or admission of the survey allegations.</p> <p>K061</p> <ol style="list-style-type: none"> <li>1. A tamper switch was installed to the main shut-off water valve to the automatic sprinkler system to monitor the system. No residents were affected.</li> <li>2. A tamper switch was installed to the main shut-off water valve to the automatic sprinkler system to monitor the system. No other residents were affected.</li> <li>3. The systemic change includes that a tamper switch was installed to the main shut-off water valve to the automatic sprinkler system to monitor the system.</li> <li>4. The Maintenance Director designee will audit via the TELs preventive maintenance system to ensure that the tamper switch remains in place. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</li> <li>5. The systemic change will be completed by December 9, 2014.</li> </ol> |                      |                                             |

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| K010067<br>SS=F    | <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on record review and interview, the facility failed to ensure 16 of 16 fire dampers in ventilating systems ductwork were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. NFPA 90A, 1999 Edition, 3.4.7, maintenance requires at least every 4 years, fusible links 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. This deficient practice affects all residents including visitors and staff.</p> <p>Findings include:</p> <p>Based on Fire Safety record review on 11/24/14 at 3:45 p.m. with the Maintenance Supervisor, documentation indicated the last fire damper inspection date was 6/21/10. Based on an interview on 11/24/14 at 3:47 p.m. with the Maintenance Supervisor, it was acknowledged the facility has exceeded</p> | K010067       | <p>K067</p> <ol style="list-style-type: none"> <li>The fire dampers in the ventilating ductwork were inspected and will be provided necessary maintenance at least every four years. No residents were affected.</li> <li>The fire dampers in the ventilating ductwork were inspected and will be provided necessary maintenance at least every four years. No other residents were affected.</li> <li>The systemic change includes that the fire dampers in the ventilating ductwork were inspected and will be provided necessary maintenance at least every four years.</li> <li>The maintenance director or designee will audit via the TELs preventive maintenance system to ensure that the fire dampers in the ventilating ductwork are inspected and provided necessary maintenance at least every four years. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee</li> </ol> | 12/09/2014           |

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| K010068<br>SS=E    | <p>the four year fire damper maintenance inspection limit.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2<br/>Based on observation and interview, the facility failed to ensure 4 of 4 gas dryers in the laundry room were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for 12 residents on 200 hall north as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/24/14 at 2:20 p.m. with the Maintenance Supervisor, the four gas fueled dryers in the laundry room on Service hall were supplied with a fresh air intake from the outside but were blocked off with cardboard and masking tape. Based on interview on 11/24/14 concurrent with the observation it was acknowledged by the Maintenance Supervisor a fresh air intake for the aforementioned gas appliances was</p> | K010068       | <p>meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>5. Systemic changes will be completed by December 9, 2014.</p> <p>K068</p> <p>1. The vents were opened up and deflectors placed to ensure that 4 of 4 gas dryers in the laundry room were provided with intake combustion air from the outside for rooms containing fuel fired equipment. No residents were affected by this.</p> <p>2. The vents were opened up and deflectors placed to ensure that 4 of 4 gas dryers in the laundry room were provided with intake combustion air from the outside for rooms containing fuel fired equipment. No other residents were affected by this.</p> <p>3. The systemic change includes that the vents were opened up and deflectors placed to ensure that 4 of 4 gas dryers in the laundry room were provided with intake combustion air from the outside for rooms containing fuel fired equipment.</p> <p>4. The Maintenance Director or designee will audit via the TELs preventive maintenance system to</p> | 12/09/2014           |

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| K010070<br>SS=E                                                                 | <p>present but was closed up with cardboard and masking tape.</p> <p>3.1-19(b)</p> <p>NFPA 101<br/>LIFE SAFETY CODE STANDARD<br/>Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to regulate the use of 2 of 2 portable space heaters in non resident rooms. This deficient practice could affect 5 residents in the front lounge as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/24/14 at 12:45 p.m. with the Maintenance Supervisor, two portable space heaters were plugged in for use and located in the Administrator's office and the front reception desk on Administrative hall.</p> <p>Based on interview on 11/24/14 concurrent with the observation, it was</p> | K010070                                                         | <p>ensure that vents remain open and deflectors remain in place. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>5. Systemic changes will be completed by December 9, 2014.</p> <p>K070</p> <p>1. Portable space heaters have been removed from 2 of 2 areas. No residents were affected by this.</p> <p>2. Portable space heaters have been removed from 2 of 2 areas. No other residents were affected by this.</p> <p>3. The systemic change includes that portable space heaters have been removed from 2 of 2 areas.</p> <p>4. The maintenance director or designee will audit via the TELs preventive maintenance system to ensure there are no portable space heaters in these areas. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee</p> | 12/09/2014           |                                             |

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|                                                                                 | acknowledged by the Maintenance Supervisor the space heaters were being used, even though the portable space heater policy indicated they could not be used in non resident rooms unless the heating elements of the portable heater did not exceed 212 degree F. No documentation pertaining to the portable space heaters was available for review.<br><br>3.1-19(b) |                                                                 |  |                                                                              | meeting and frequency and duration of reviews will be adjusted as needed.<br><br>5. Systemic changes will be completed by December 9, 2014. |                                             |                      |