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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258 | X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____ | X3) DATE SURVEY COMPLETED 11/06/2013 |
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| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016 |
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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: 11/06/13</p> <p>Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Countryside Manor Health & 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 in spaces open to the corridors with battery operated smoke</p> | K010000 | | |
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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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| | <p>detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 97 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 Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/14/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> | | | |

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| K010029 SS=E | <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 12 doors to hazardous areas such as the kitchen door would self close and latch securely into its frame. This deficiency could affect 8 residents in the Main dining room and 12 residents on 200 northwest hall both adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 11/06/13 at 1:45 p.m. with the Maintenance Supervisor, the kitchen door adjacent to the Main dining room and the kitchen door which opens up into the service corridor were not provided with a self closing device on each door. Based on interview on 11/06/13 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the</p> | K010029 | <p>K029 1. Self-closing devices were installed such that the two doors will close and latch without assistance. No residents were affected. 2. Other doors requiring a self-closing device have been checked and any issues identified have been corrected. 3. The systemic change will be that the self-closing devices will remain in place for the doors which require a self-closing device. 4. The doors that require the self-closing devices will be checked quarterly per the TELs preventive maintenance program to ensure their functionality by the Maintenance Director or designee. 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. 5. Systemic changes will be completed by December 6, 2013.</p> | 12/06/2013 | | | |

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| | <p>aforementioned kitchen doors were not provided with a self closing device to ensure the doors would close and latch without assistance.</p> <p>3.1-19(b)</p> | | | |

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| K010062 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 private fire hydrants was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation on 11/06/13 at 3:09 p.m. with the Maintenance Supervisor, there was one fire hydrant on facility property observed by the front entrance. Based on review of Fire Systems report on 11/06/13 at 4:21 p.m. with the Maintenance Supervisor, the facility lacked documentation of an annual inspection for the private fire hydrant next</p> | K010062 | <p>K062 1. The fire hydrant was inspected on (date). See attachment A). No residents were affected. 2. The fire hydrant was inspected and there were no further recommendations. 3. The systemic change includes that the fire hydrant will be inspected annually. 4. The maintenance director or designee will audit via the TELs preventive maintenance system to ensure that the fire hydrant is inspected per the schedule. 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. 5. Systemic changes will be completed by December 6, 2013.</p> | 12/06/2013 | | | |

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| | <p>to the front entrance walkway. Based on interview concurrent with record review with the Maintenance Supervisor, it was confirmed documentation of an annual fire hydrant inspection was not available for review and the facility was unaware the fire hydrant needed to be serviced annually.</p> <p>3.1-19(b)</p> | | | |

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| K010066 SS=E | <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 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. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 3 areas where smoking was permitted. This deficient practice could affect 12 residents on Northwest hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/06/13 at 1:15 p.m. with the Maintenance Supervisor, over 100 extinguished cigarette butts were</p> | K010066 | K066 1. Cigarette butts were disposed of properly. 2. There are no other smoking areas. All areas have proper mechanism for disposing of cigarette butts appropriately. 3. The employee smoking area will be checked weekly to ensure proper disposal of cigarette butts. 4. The maintenance director or designee will audit monthly via the TELs preventive maintenance system to ensure that the smoking area is checked. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and | 12/06/2013 | | | |

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| | <p>observed strewn about on the ground outside the Northwest exit. Based on review of the smoking policy on 11/06/13 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 11/06/13 at 1:17 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts on the ground instead of into an approved container.</p> <p>3.1-19(b)</p> | | <p>frequency and duration of reviews will be adjusted as needed. 5. Systemic changes will be completed by December 6, 2013.</p> | | | | |

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| K010067 SS=F | <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. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observations and interview, the facility failed to ensure 65 of 65 resident rooms were not using the corridor as a portion of a return air system/plenum for the heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice could affect 97 residents as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observation on 11/06/13 during a tour of the facility between 1:33 p.m. and 3:45 p.m. with the Maintenance Supervisor, the sixty five resident rooms located in the facility were using the egress corridors as a return air system.</p> <p>Based on interview on 11/06/13 concurrent with the observations with the Maintenance Supervisor, it was confirmed the return air was exhausted into the corridor for the aforementioned resident</p> | K010067 | K067 1. The recommended waiver has been submitted to the LSC Supervisor and is pending approval. 2. No other areas are affected by this requested waiver. Application for waiver has been requested previously. 3. Education was provided to the Maintenance supervisor for the requirement and request of waiver. Status of waiver will be reviewed. 4. Status of waiver will be monitored by the Maintenance Director or designee through the Monthly quality assurance Committee meeting and frequency and duration reviews will be adjusted as needed. 5. Systemic changes will be completed by December 6, 2013. | 12/06/2013 | | | |

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| | rooms. 3.1-19(b) | | | |