

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 11/26/2014
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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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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: 11/26/14</p> <p>Facility Number: 012534 Provider Number: 155792 AIM Number: 201028420</p> <p>Surveyor: Mark Caraher, Life Safety Code Specialist</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</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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K010025 SS=E	<p>system in all resident sleeping rooms. The facility has a capacity of 171 and had a census of 140 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 by Dennis Austill, Life Safety Code Specialist on 12/05/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings in 1 of 14 smoke barriers were protected to maintain the one hour fire resistance</p>	K010025	All holes discovered in 1 of 14 smoke barriers at time of inspection have been repaired to ensure one hour fire resistance rating	12/15/2014			

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K010062 SS=C	<p>rating of the smoke barrier. This deficient practice could affect 22 residents, staff or visitors in the vicinity of the smoke barrier wall near Room 410.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/26/14, the attic smoke barrier wall above the ceiling at the corridor door set by Room 410 had three holes in the five eights inch layer of drywall on the south side of the wall which failed to maintain a one hour fire resistance rating. One hole measured three feet by three feet, the second hole measured two feet by one foot and the third hole measured one foot by one foot. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned the smoke barrier openings were not firestopped to maintain a one hour fire resistance rating of the smoke barrier.</p> <p>3.1-19(b)</p> <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,</p>		<p>An inspection of all smoke barriers will be conducted on a weekly basis for 60 days, then monthly for 120 days then quarterly thereafter to ensure deficient practices are corrected moving forward. * Documentation of repair is attached</p>				

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	<p>NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to document weekly fire pump inspection, testing and maintenance for 1 of 1 fire pumps for the most recent twelve month period. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. NFPA 25, Chapter 5-1.1 provides the minimum requirements for the routine inspection, testing, and maintenance of fire pump assemblies. Table 5-1.1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Chapter 5-3.2.1 requires a weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes.</p> <p>Exception: A valve installed to open as a safety feature shall be permitted to discharge water.</p> <p>5-3.2.2.1. The automatic weekly test timer shall be permitted to be substituted for the starting procedure.</p>	K010062	<p>An inspection of the fire pump has been conducted as of 12/15/14</p> <p>A weekly inspection will be conducted on the fire pump system moving forward This inspection will provide no less than the minimum requirements for the routine inspection, testing and maintenance of the fire pump assemblies required by NFPA 25, Chapter 5 -1-1</p> <p>This inspection has been added to the facilities preventative maintenance program and will be available for review upon any further inspections</p>	12/15/2014	

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	<p>The pertinent visual observations specified in Chapters 5-2.2.1, through Chapter 5-2.2.3 shall be performed weekly. Chapter 1-8 states records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of BBC Pump & Equipment Company "Fire Pump Test Results" documentation dated 09/24/14 and "Fire Sprinkler Main Pump Inspection Log" quarterly fire pump inspection documentation with the Maintenance Director during record review from 9:30 a.m. to 10:50 a.m. on 11/26/14, documentation of weekly fire pump inspection, testing and maintenance for 45 of 52 weeks during the most recent twelve month period was not available for review. An annual test of the electric motor-driven pump assembly was conducted as documented in the 09/24/14 inspection documentation and quarterly tests and inspections were conducted by the facility in November 2013, and February, March, June, August and November 2014. Based on interview at the time of record review, the</p>			

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K010064 SS=E	<p>Maintenance Director stated he was unaware weekly fire pump inspection, testing and maintenance was required and acknowledged documentation of weekly fire pump inspection, testing and maintenance for 45 of 52 weeks during the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 Based on observation and interview, the facility failed to ensure 1 of over 15 portable fire extinguishers had pressure gauge readings in the acceptable range. LSC 4.5.6 requires any fire protection system, building service equipment, feature of protection or safe guard provided for life safety shall be designed, installed and approved in accordance with applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient</p>	K010064	<p>A new fire extinguisher has been installed in the 400 Hall recreation room All facility extinguishers have been inspected in order to meet NFPA requirements All extinguishers will be inspected monthly to ensure proper functioning and pressure An annual fire extinguisher inspection will be conducted to meet all NFPA requirements</p>	12/15/2014

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K010130 SS=E	<p>practice could affect 10 residents, staff or visitors in the 400 Hall Recreation Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/26/14, the pressure gauge on the portable fire extinguisher in the 400 Hall Recreation Room by the sink showed the extinguisher was undercharged. The inspection tag on the portable fire extinguisher listed the most recent annual inspection was in March 2014 and the most recent monthly inspection was in November 2014. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned portable fire extinguisher pressure gauge indicated the fire extinguisher was undercharged.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors were in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this</p>	K010130	<p>A full inspection was conducted on 1 of 1 rolling fire doors was conducted on 12-11-15 A monthly inspection of proper operation will be conducted in regards to the full operation of the rolling fire door and has been added to the monthly facility</p>	12/15/2014			

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	<p>Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 20 residents, staff and visitors in the Main Dining Room.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Director from 9:30 a.m. to 10:50 a.m. on 11/26/14, documentation of rolling fire door inspection within the most recent twelve month period was not available for review. Based on observation with the Maintenance Director during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/26/14, one metal rolling fire door protecting the opening from the kitchen to the Main Dining Room was noted and no inspection documentation was affixed to the door. Based on interview at the time</p>		<p>preventative maintenance program An annual inspection will be conducted to ensure that proper functioning of rolling fire door moving forward.</p>				

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K010147 SS=D	<p>of record review and of the observation, the Maintenance Director acknowledged documentation of an annual inspection or test to check for proper operation and full closure of the metal curtain within the most recent twelve month period was not available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 extension cords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect four staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:50 a.m. to 1:55 p.m. on 11/26/14, a microwave oven was plugged into a power strip in the 400 Hall MDS Coordinator's Office and in the Human Resources Office. Based on interview at</p>	K010147	<p>The power strip that were used in the MDS office and Human Resources office has now been removed in accordance with NFPA70, Article 400-8</p> <p>All other rooms in the facility have been inspected to ensure there is no use of power cords in accordance with NFPA70, Article 400-8</p> <p>Weekly inspections will be conducted for 30 days, monthly inspections will be conducted for 120 days and quarterly thereafter to ensure that no power cords are in use in compliance with NFPA 70, Article 400-8</p>	12/15/2014			

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	the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring in the aforementioned locations. 3.1-19(b)				