STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING -- B. WING	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY	205 MARINE DR ANDERSON, IN 46016

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E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 01/02/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/06/24 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190 At this PSR survey, Countryside Manor Health and Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 109 certified beds. At the time of the survey, the census was 71. Quality Review completed on 02/08/24	E 0000		
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Recertification and State Licensure Survey conducted on 01/02/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/06/24 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Ingram	Director of Operations	02/23/2024

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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	At this PSR survey, Countryside Manor Health and Living Community 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 fully sprinkled with exception of three electrical closets. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 71 at the time of this visit. All areas where residents have customary access were sprinklered except for a garage and a shed which houses the generator and were not sprinklered. Quality Review completed on 02/08/24			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.			

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	In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 2 of 3 electrical closets were provided with adequate coverage to ensure the facility was protected throughout by an approved automatic sprinkler system in accordance with NFPA 13. This deficient practice could up to 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 02/02/24 at 1:15 p.m., the cabinets built around electrical panels in the kitchen and therapy storage room did have the front doors taken off, but sprinkler was on the right side of the cabinet. This condition still does not provide proper sprinkler coverage due to the side of the cabinet was blocking the spray pattern for the sprinkler. The inside space measured 3 feet by 6 feet. Based on interview at the time of observation, the Maintenance Director agreed the space inside the cabinets was not fully protected and the Administrator stated their sprinkler contractor is scheduled to move the sprinkler heads for proper coverage. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. This deficiency was cited on 01/02/24. The facility	K 0351	February 16, 2024 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: VCVM22 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on January 2, 2024 with a revisit on February 6, 2024. This letter is to inform you that the plan of correction attached is to serve as Countryside Health & Living Community's credible allegation of compliance. We allege substantial compliance effective 2/15/2024. We are requesting paper compliance for this plan of correction. If you have any further questions,	02/15/2024

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	failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		please do not hesitate to contact me at 765-649-4558 Sincerely, Keeshan Patel, HFA Administrator Countryside Health and Living Submission of this plan of correction in no way constitutes an admission by Countryside Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	

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			K 351 **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Sprinkler heads have been installed for the two electrical closets to provide adequate coverage in accordance with NFPA 13. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** Staff and up to 30 residents could be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Sprinkler heads have been installed to cover affected areas. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will	

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			inspect all closets and areas during their annual CQR to ensure proper fire protection. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2024.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where			

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	smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed enforce 1 of 1 non-smoking policies and ensure cigarette butt were disposed in a non-combustible container with a self-closing lid. This deficient practice could affect staff around the employee entrance and 12 residents using the 300-hall exit. Findings include: Based on observations with the Maintenance Director on 02/06/24 at 1:10 p.m., smoking on property was evident due to the following: b) There were over 50 cigarette butts on the ground outside the employee entrance. c) The trashcan by the employee entrance was mixed with cigarette butts and trash. e) There were over 40 cigarette butts on the ground around the picnic table next to the garage. Based on records review at 1:11 p.m., the smoking policy stated the facility may choose to allow or not allow smoking on campus. This facility chose to be a non-smoke facility and had "no smoking" placards on the exterior of the building. Based on interview at the time of observation and records review, the Maintenance Director stated the facility is a non-smoking campus and confirmed there was smoking on property due to cigarette butts on the ground. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. This deficiency was cited on 01/02/23. The facility failed to implement a systemic plan of correction to prevent recurrence.	K 0741	**K 741** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Cigarette butts were removed from the property. **II. The facility will identify other residents who may potentially be affected by the deficient practice.** Staff and residents could be affected. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and housekeeping/designee will make multiple rounds daily to ensure that cigarette butts are not present on the property and the policy is being enforced. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will	02/15/2024

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	3.1-19(b)		inspect all outside areas during their annual CQR to ensure the non smoking policy is being enforced. **V. Plan of Correction completion date.** Plan of Completion date is February 15, 2024.	