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	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/13/22 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190 At this Emergency Preparedness survey, Countryside Manor Health and Living Community was found in substantial 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 58. Quality Review completed on 10/17/22	E 0000	November 1, 2022 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: IRGI21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on October 13, 2022. This letter is to inform you that the plan of correction attached is to serve as Countryside Health & Living Community credible allegation of compliance. We allege substantial compliance on. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 765-649-4558 Sincerely, Keeshan Patel, HFA Administrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keeshan Patel		11/02/2022

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.

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	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			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.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1)			

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	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National			

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	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			

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	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/13/22 between 9:45 a.m. and 12:10 p.m., the facility provided documentation for testing of the emergency generator, however could not provide documentation of a three year 4 hour test. The Director of Maintenance stated that there was confusion with the contract with the new vendor and the past test was from 2018. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m.	E 0041	**E041** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility generator had a documented 4-hour load bank test. The previous test was from 2018 and needs to be completed every 3 years. The Maintenance Supervisor has contracted with Cummins Crosspoint to do the 4-hour load bank test at their next scheduled service. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to have a 4-hour load bank test completed every 3 years. See attached TELS task labeled "Countryside Generator Maintenance"	11/15/2022

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	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities is changing the contract with Cummins to include the load bank testing every 3 years. **V. Plan of Correction completion date.** Plan of Completion date is Nov. 15th.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/13/22 Facility Number: 000160 Provider Number: 155258 AIM Number: 100267190 At this Life Safety Code 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.	K 0000	November 1, 2022 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: IRGI21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on October 13, 2022. This letter is to inform you that the plan of correction attached is to serve as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	This one story facility was determined to be of Type V (000) construction and fully sprinkled. 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 healthcare portion of the facility has a capacity of 109 and had a census of 58 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 10/17/22		Countryside Health & Living Community credible allegation of compliance. We allege substantial compliance on. We are requesting paper compliance for this plan of correction. If you have any further questions, 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.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 8 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 20 residents. Findings include: Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., in the corridor outside the maintenance office there were 3 wooden nightstands against the wall protruding into the corridor about two feet. Additionally, there were several chairs which were recently delivered and belonged in the new dialysis area. The aforementioned chairs were being relocated during the survey. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)	K 0211	**K 211** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that one of eight facility corridors were free of obstructions. The Maintenance Supervisor had removed the items from this area. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could have been affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance supervisor will complete daily audits for 2 weeks, recorded on TELS to ensure that	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			the facility corridors will stay clear of any obstructions. **IV The facility will monitor the corrective action by implementing the following measures.** The Maintenance Supervisor has updated his new employee orientation to include talking about always leaving all paths of egress clear. **V. Plan of Correction completion date.** Plan of Completion date is October 28th.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and Interview, the facility failed to ensure 1 of 1 delayed egress locking arrangements in the 600 hall was installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 15 residents. Findings include: Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., the double door exit near resident room 327 had a sticker indicating the door opened with a 15 second delayed mechanism. When the exit doors were tested the irreversible process to release the lock was not initiated. Based on interview at the time of observation, the code pad was provided with a posted code and the Director of Maintenance stated that the delayed egress	K 0222	**K 222** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the exit door indicated that there is a 15 second delayed mechanism, but the relay was not initiated. The facility removed inaccurate signage on the door as there is a code posted next to the door. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by the deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance supervisor was reeducated on the correct means of egress and where and when	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	signage needed to be removed if the code was being posted. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		codes need to be posted. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all egress doors during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is Oct 18th.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 8 residents and staff using the Administrative Exit. Findings include: Based on observations during a facility tour and	K 0271	**K 271** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the exit discharge from the office area had a level walking surface. There is currently stairs	12/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., the exit discharge from the Administrative Office area, used primarily by administrative employees, had 3 steps and was an uneven grade. Additionally, the stairs did not have a handrail on either side. Based on interview at the time of observation, the Director of Maintenance acknowledged that three steps were present and the exit discharge did not have a complete level walking surface that was free of obstructions leading to the common way. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		at this location. Yoder Concrete has been contracted to remove the stairs and install a ADA complaint ramp system to this location. When completed an update will be sent to ISDH. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All office staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This correction is a final so there will be no long term follow up. **IV The facility will monitor the corrective action by implementing the following measures.** This correction is a final so there will be no long term follow up. **V. Plan of Correction completion date.** Plan of Completion date is 12/1.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 18 residents, as well as staff and visitors. Findings include:	K 0321	**K 321** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., Room 343, greater than 50 square feet, contained a number of combustible items, such as, 3 tables, 6 chairs and other paper and wood products. The corridor door to this room was not equipped with a self-closing device. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		The community failed to ensure that a storage room was not equipped with a self-closing devise. Items from this room was removed and turned back into a residential room. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance director will complete monthly audits to ensure that no rooms are being improperly used for storage, recorded on TELS. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor the community to ensure all areas are being used for their intended use. **V. Plan of Correction completion date.** Plan of Completion date is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			October 28th.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to maintain 1 of 3 corridor doors for cooking facilities that serve 30 or more residents to ensure cooking facilities are protected and not open to the corridor. This deficient practice affects 40 residents in the dining area. Findings include: Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., the double set of corridor serving doors	K 0324	**K 324** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that a set of double doors in the kitchen leading to the dining hall were on self-closing hinges. The Maintenance Supervisor has	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	from the kitchen into the dining area failed to self-close and latch. The doors were held open with magnet holders and were integrated into the fire alarm system. The double serving doors were not equipped with a self-closing device or self-closing hinges. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		installed self-closing hinges on these doors. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All kitchen staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** This is a permanent fix so no follow up will be needed. **IV The facility will monitor the corrective action by implementing the following measures.** This is a permanent fix so no follow up will be needed. **V. Plan of Correction completion date.** Plan of Completion date is Oct 28th.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/13/22 between 9:45 a.m. and 12:10 p.m., no documentation for a complete current smoke detector sensitivity test was available for review. The report dated 1/8/20 was the last sensitivity report and it stated the next would be due on 1/8/22, however no current documentation was provided. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery	K 0345	**K 345** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that a compliant smoke detector sensitivity test was available for review. The Maintenance Supervisor has contracted with Cintas Fire to conduct the test. When testing is completed the documentation will be sent to ISDH. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**	11/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	and again during the exit conference at 3:45 p.m. 3.1-19(b)		The current TELS task has been updated with the proper timing to ensure it is completed every 5 years. See attached TELS task labeled "Countryside Sensitivity Testing" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor the testing frequency during their annual CQR inspections. **V. Plan of Correction completion date.** Plan of Completion date is Nov 1st.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in the boiler room. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 15 residents in one smoke compartment. Findings include: Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., in the boiler room there were 2 missing sections of 2X4 foot ceiling tiles. This condition could delay the activation of the sprinklers installed in the ceiling. Based on interview at the time of observation, the Director of Maintenance agreed there was missing ceiling tiles and stated that electricians were recently in the facility. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)	K 0353	**K 353** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that two ceiling tiles were in place in the boiler room. The maintenance Supervisor has re installed the ceiling tiles. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and Contractors have been reeducated to replace ceiling tiles once they are done in the ceiling. **IV The facility will monitor**	10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			the corrective action by implementing the following measures. CarDon Corporate Facilities will inspect all mechanical rooms during their annual CQR inspections to ensure the ceiling tiles are in place. **V. Plan of Correction completion date.** Plan of Completion date is Oct 18th.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff and 15 residents. Findings include: Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) The Therapy Corridor Door, equipped with a self-closing device. b) The "Staff" room across from resident room # 327, equipped with self-closing hinges. c) The Pantry door on the 300 hall equipped with a self-closing device hit the door jamb and	K 0363	**K 363** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure three doors did not latch positively into their respective door frames. The Maintenance Supervisor has audited all doors in the facility and ensured that doors do latch, if they did not he adjusted the door so that they do latch. **II. The facility will identify other residents that may potentially be affected by the**	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	did not close. The Director of Maintenance stated that the corporate office was aware of the door issue. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		**deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current monthly TELS task in place to audit all doors to ensure the latch. See attached TELS task labeled “Countryside Door and Latch Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all doors and latching devices during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is Oct 28th.	
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 3 of 3 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect 4 staff. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/13/22 between 9:45 a.m. and 12:10 p.m., the facility's water heaters did not have current documentation to show when they were inspected. The certificates provided showed an expiration of 2019 for all the water heaters. The Director of Maintenance stated that they are working with their insurance company to resolve the issues. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)	K 0500	**K 500** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility water heaters did not have current documentation to show when they were inspected. CarDon Corporate Facilities has changed their insurance company that does these inspections, and the new provider has been contacted for inspection. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The maintenance supervisor was reeducated on when inspections	11/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			for water heaters are due. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all boilers for the proper inspections during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is Nov 2nd.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes in the Riser room were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice	K 0511	**K 511** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that one junction box cover was intact above a drop ceiling. The Maintenance Supervisor has	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	could affect staff and 6 residents. Findings include: Based on observations during a facility tour and interview with the Administrator and Director of Maintenance on 10/13/22 between 12:10 p.m. and 2:45 p.m., an electrical junction box above the drop ceiling near the Speech Therapy room, did not contain a cover and had exposed electrical wiring hanging out of the box. Based on interview at the time of the observations, the Director of Maintenance acknowledged the electrical junction box was not provided with a cover and had exposed wires. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		installed a cover on the junction box. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor was reeducated on the deficient practice that a junction box cover is always required. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect above all drop ceilings during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is Oct 28th.	
K 0761 SS=E				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is,	K 0761	**K 761** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to maintain that the oxygen transfilling room had the annual fire door inspection. CarDon Corporate Facilities has inspected the community and updated all their paperwork to include the oxygen room door. See attached paperwork. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor and home office support have been educated that all doors that are fire doors are to be inspected in the annual fire door inspection. **IV The facility will monitor**	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 20 residents. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/13/22 between 9:45 a.m. and 12:10 p.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. The last report showing an inspection of the O2 room was dated 3/8/21. The current 3/1/22 inspection report did not include the O2 room door. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review and observation, the Director of Maintenance stated the annual fire door inspection was not completed within the last year. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		**the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all fire doors during their annual door inspection. **V. Plan of Correction completion date.** Plan of Completion date is Oct 28th.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failure to ensure 3 of 3 portable space heaters were not used in the facility. This deficient practice could affect up to 6 residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/13/22 between 9:45 a.m. and 12:10 p.m., portable space heater s were in use in (1) Administrators Office (2) Social Services Office and (3) Medical Records Office. Provided Manufacturer's documentation for the portable space heaters indicated wattage but did not state the maximum temperature achieved by the unit. Based on interview at the time of observation, the Director of Maintenance stated portable space heaters are not allowed to be used in the facility but acknowledged a portable space heater was used at the aforementioned locations. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)	K 0781	**K 781** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that portable heaters in the building listed the maximum temperature achieved by the unit. All previous portable heaters have been removed. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The maintenance supervisor and	10/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			department heads have been educated on the types of portable heaters that can be used in the facility. A Monthly TELS task is in place to inspect the entire community to ensure there are not space heaters in use. See attached TELS Task Labeled "Countryside Portable Heaters" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will entire community to ensure there are not space heaters during their annual CQR. **V. Plan of Correction completion date.** Plan of Completion date is Oct 28th.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants.	K 0918	**K918** **I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure that the facility generator had a documented 4-hour load bank test. The previous test was from 2018 and needs to be completed every 3 years. The Maintenance Supervisor has contracted with Cummins Crosspoint to do the	11/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 01 B. WING	10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 10/13/22 between 9:45 a.m. and 12:10 p.m., the facility provided documentation for testing of the emergency generator, however could not provide documentation of a three year 4 hour test. The Director of Maintenance stated that there was confusion with the contract with the new vendor and the past test was from 2018. The finding was reviewed with the Administrator and Maintenance Director at the time of discovery and again during the exit conference at 3:45 p.m. 3.1-19(b)		4-hour load bank test at their next scheduled service. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to have a 4-hour load bank test completed every 3 years. See attached TELS task labeled "Countryside Generator Maintenance" **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities is changing the contract with Cummins to include the load bank testing every 3 years. **V. Plan of Correction completion date.** Plan of Completion date is Nov. 15th.	