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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/07/2014 |
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| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY | STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 30, October 1, 2, 3, 6, and 7, 2014</p> <p>Facility number: 000160 Provider number: 155258 AIM number: 100267190</p> <p>Survey Team: Ginger McNamee, RN-TC Karen Lewis, RN Toni Maley, BSW</p> <p>Census bed type: SNF: 20 NF: 78 Total: 98</p> <p>Census payor type: Medicare: 28 Medicaid: 48 Other: 22 Total: 98</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by Debora Barth, RN.</p> | F000000 | | |

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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| F000279 SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop a care plan for a resident with insomnia for 1 of 2 residents reviewed with insomnia (Resident #165).</p> <p>Finding includes: Resident #165's clinical record was reviewed on 10/2/14 at 1:45 p.m. Resident #165's current diagnoses included, but were not limited to, depression, arthritis, aphasia, dysphasia,</p> | F000279 | This plan of correction is to serve as Countryside ManorHealth and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute anadmission by Countryside Manor Health and Living Community or its managementcompany that the allegations contained in the survey report is a true andaccurate portrayal of the provision of nursing care and other services in thisfacility. Nor | 10/22/2014 |

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| | <p>anxiety, pain and weakness. Resident #165 had a current, 7/29/14, physician's order for trazadone (an antidepressant also used as a sleep aid) 50 mg - 1 tablet at bedtime for insomnia. During the 10/2/14 record review, Resident #165 had no care plan for insomnia, nor documented non pharmacological approaches to treat insomnia.</p> <p>During a 10/3/14, 12:35 p.m., interview, the Director of Nursing indicated Resident #165 did not have a care plan to address insomnia prior to 10/3/14.</p> <p>A current, October 2010, facility policy, titled "Care Plans - Comprehensive", which was provided by the Administrator on 10/7/14 at 1:55 p.m., indicated the following: "An individualized comprehensive care plan that includes, measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Policy Interpretation and Implementation ... 3. Each resident's comprehensive care plan is designed to: a. In corporate identified problem areas."</p> | | <p>does this submission constitute an agreement or admission of the survey allegations. F279 1. Resident #165 has a care plan for insomnia. 2. Other residents with medications used to treat insomnia have the potential to be affected. All residents receiving medications for insomnia have been reviewed and care plans are in place. 3. The systemic change includes that licensed nurses will be educated that residents receiving medications to treat insomnia will have a care plan in place. All new orders for medications to treat insomnia will be audited daily Monday through Friday during the clinical meeting to determine a care plan is in place. 4. The Director of Nursing or designee will audit residents with a new order for a medication to treat insomnia to determine a care plan addressing the condition is in place daily Monday through Friday for the next month; three times per week for the next five months and weekly thereafter to total 12 months of monitoring. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. 5. Systemic changes will be completed by October 22, 2014.</p> | | |

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| F000309 SS=D | <p>3.1- 35(a)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to assess a diabetic resident when blood sugar results were elevated for 1 of 3 residents reviewed for diabetic care. (Resident #157)</p> <p>Findings include:</p> <p>The clinical record for Resident #157 was reviewed on 10/3/14 at 8:25 a.m. Diagnoses for Resident #157 included, but were not limited to, diabetes, hypertension, and depression.</p> <p>Current physician's orders for Resident #157 included, but were not limited to, the following orders:</p> <p>a. Humalog KwikPen (insulin) 5 units subcutaneous with meals. The original date of this order was 5/5/14.</p> <p>b. Lantus (insulin) 15 units subcutaneous once a morning. The original date of this</p> | F000309 | <p>F309</p> <p>1. The physician for#157 has been notified of all blood sugar results. Resident #157 has a physician order in place for blood sugar parameters and notification to the MD.</p> <p>2. Other residents with glucometer testing were reviewed to determine there were blood sugar parameters in place. Any issues identified were notified to the family and MD and orders clarified as needed.</p> <p>3. The systemic change includes that the licensed nurses will be educated that all residents receiving glucometer testing will have parameter orders in place to assure notification to the MD. All new orders for glucometer testing will be reviewed Monday through Friday during the clinical meeting to assure parameter orders are in place.</p> <p>4. The Director of Nursing will audit all new orders for residents with glucometer testing Monday</p> | 10/22/2014 | |

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| | <p>order was 5/2/14.</p> <p>c. Check blood sugars prn (as needed). The original date of this order was 10/14/13.</p> <p>Resident #157 had a current, 10/01/13 dated, health care plan problem of potential complications related to diabetes mellitus. One of the approaches for this problem was to monitor for signs of hyperglycemia (high blood sugar). Another approach for this problem was to monitor/record/report blood sugars per facility schedule, policy, and physician order.</p> <p>Review of the current, revised 10/2010, facility policy, titled "Nursing Care of the Resident with Diabetes Mellitus," provided by the Administrator on 10/6/14 at 10:22 a.m., included, but was not limited to,</p> <p>"...Glucose Monitoring... ...4. 'Finger sticks' (capillary blood samples) measure current blood glucose levels.... ...b. Normal ranges are approximately 90-130 mg/dl before meals and < [less than] 180 mg/dl after meals. c. Hyperglycemia is considered anything above target reference ranges...."</p> | | <p>throughFriday to assure parameter orders are in place for the next month; three timesper week for the next five months and weekly thereafter to total 12 months ofmonitoring.</p> <p>Results of these audits will be reviewed at the monthlyfacility Quality Assurance Committee meeting and frequency and duration ofreviews will be adjusted as needed.</p> <p>5. Systemic changeswill be completed by October 22, 2014.</p> | |

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| | <p>Review of the August and September 2014, Medication Administration Records (MAR) indicated elevated blood sugar results greater than 350 mg/dl for the following dates and times:</p> <p>August 1, 5:30 p.m., the blood sugar result was 365.</p> <p>August 6, 8:00 a.m., the blood sugar result was 388.</p> <p>August 6, 12:00 p.m., the blood sugar result was 424.</p> <p>August 6, 5:30 p.m., the blood sugar result was 390.</p> <p>August 12, 5:30 p.m., the blood sugar result was 367.</p> <p>August 13, 5:30 p.m., the blood sugar result was 401.</p> <p>August 15, 5:30 p.m., the blood sugar result was 396.</p> <p>August 19, 12:00 p.m., the blood sugar result was 372.</p> <p>August 19, 5:30 p.m., the blood sugar result was 450.</p> <p>August 20, 8:00 a.m., the blood sugar</p> | | | |

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| | <p>result was 370.</p> <p>August 20, 12:00 p.m., the blood sugar result was 444.</p> <p>August 20, 5:30 p.m., the blood sugar result was 362.</p> <p>August 22, 8:00 a.m., the blood sugar result was 363.</p> <p>August 23, 12:00 p.m., the blood sugar result was 374.</p> <p>August 23, 5:30 p.m., the blood sugar result was 409.</p> <p>August 24, 12:00 p.m., the blood sugar result was 366.</p> <p>August 25, 12:00 p.m., the blood sugar result was 377.</p> <p>August 25, 5:30 p.m., the blood sugar result was 411.</p> <p>August 26, 12:00 p.m., the blood sugar result was 383.</p> <p>August 27, 12:00 p.m., the blood sugar result was 361.</p> <p>August 29, 5:30 p.m., the blood sugar result was 372.</p> | | | |

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| | <p>August 30, 5:30 p.m., the blood sugar result was 468.</p> <p>August 31, 12:00 p.m., the blood sugar result was 414.</p> <p>September 1, 5:30 p.m., the blood sugar result was 351.</p> <p>September 3, 5:30 p.m., the blood sugar result was 422.</p> <p>September 18, 5:30 p.m., the blood sugar result was 588.</p> <p>September 21, 5:30 p.m., the blood sugar result was 373.</p> <p>September 22, 8:00 a.m., the blood sugar result was 362.</p> <p>September 22, 12:00 p.m., the blood sugar result was 420.</p> <p>September 26, 5:30 p.m., the blood sugar result was 470.</p> <p>The clinical record lacked assessments for the dates and times the resident had blood sugar results above the targeted reference ranges stated in the facility policy. This resulted in 30 times, during</p> | | | |

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| F000325 SS=D | <p>August and September, 2014, Resident #157 had a blood sugar result above 350 mg/dl, which was 120 points greater than the targeted reference ranges stated in the facility policy.</p> <p>During an interview with the Director of Nursing (DON) on 10/7/14 at 2:30 p.m., she indicated residents should have individualized blood sugar parameters for actions by the nurses, notifying the physician, and determining appropriate nursing treatment. She further indicated Resident #157 did not have these established parameters. When questioned, the DON indicated the policy was lacking in direction for nursing if resident had a high blood sugar result.</p> <p>3.1-37(a)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is</p> | | | |

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| | <p>a nutritional problem.</p> <p>Based on record review, observation, and interview, the facility failed to implement recommendations from the Registered Dietician for 1 of 4 residents reviewed for nutritional risk. (Resident #131)</p> <p>Findings include:</p> <p>The clinical record for Resident #131 was reviewed on 10/2/14 at 12:40 p.m. The diagnoses for Resident #131 included, but were not limited to, diabetes, dysphagia, and depression.</p> <p>A quarterly Minimum Data Set assessment, dated 9/2/14, indicated Resident #131 had severe cognitive impairment.</p> <p>Resident #131's weight history included, but was not limited to, the following:</p> <p>9/1/14 - 103.3 lbs 8/6/14 - 110.8 lbs. 7/8/14 - 111.7 lbs.</p> <p>A Registered Dietician Progress Note, dated 9/3/14, indicated the dietician recommended a Magic Cup (nutritional supplement) twice a day between meals to "arrest further weight loss."</p> <p>Resident #131's record lacked a</p> | F000325 | <p>F325</p> <ol style="list-style-type: none"> 1. The RD recommendation for resident #131 has been followed through. Resident is receiving her supplement as ordered. 2. Other residents with dietary recommendations in the past 30 days were reviewed to determine their recommendations were followed up on. 3. The systemic change includes that education was provided to licensed nurses regarding notifying the MD of Registered Dietician recommendations. All new Registered Dietician recommendations will be reviewed weekly by the DON or designee to determine their recommendation was communicated to the MD for orders. 4. The Director of Nursing or designee will audit the follow through for the RD report weekly for the next twelve months. 5. Systemic changes will be completed by October 22, 2014. | 10/22/2014 |

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| F000329 SS=D | <p>physician's order for a Magic Cup.</p> <p>During an interview with the Director of Nursing (DON) on 10/6/14 at 10:32 a.m., additional information was requested related to the lack of the dietician's recommendation of a Magic Cup twice a day between meals for Resident #131.</p> <p>During an interview with the DON on 10/6/14 at 1:33 p.m., she indicated the dietician's recommendation of a Magic Cup twice a day between meals for Resident #131 had not been implemented.</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic</p> | | | | | | |

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| | <p>drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to administer sliding scale insulin as ordered by the physician. and failed to ensure blood sugars were rechecked if needed per parameters as ordered by the physician for 1 of 5 residents reviewed for unnecessary medications. (Resident #131)</p> <p>Findings include:</p> <p>The clinical record for Resident #131 was reviewed on 10/2/14 at 12:40 p.m. The diagnoses for Resident #131 included, but were not limited to, diabetes, dysphagia, and depression.</p> <p>Current physician's orders for Resident #131 included, but were not limited to, the following orders:</p> <p>a. Januvia (an oral diabetic medication) 50 milligram (mg) 1 tablet by mouth once a day. The original date of this order was 9/10/14.</p> <p>b. Check blood sugars before meals and</p> | F000329 | <p>F329</p> <p>1. The MD forresident #131 has been notified of all blood sugar results and concerns withinsulin administration.</p> <p>2. Other residents with sliding scale insulin orders werereviewed for the past 30 days to determine the correct amount of insulin hasbeen administered and notification of blood sugar results outside the orderedparameters were communicated to the MD. Any issues identified were notified to the family and MD and ordersclarified as needed.</p> <p>3. The systemicchange includes that licensed nursing staff were educated regardingadministering the correct amount of insulin and notification of the MD if bloodsugars are out of ordered parameters.</p> <p>4. The Director of Nursing or designee will audit residentswith sliding scale insulin for correct amounts of insulin and notification ofthe MD if blood sugars are out of parameters Monday through Friday for the nextmonth; three times per</p> | 10/22/2014 |

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| | <p>at bedtime. The original date of this order was 2/1/13.</p> <p>c. Administer Novolog sliding scale insulin according to blood sugar results as listed below,</p> <p>151-200 = 2 units 201-250 = 4 units 251-300 = 6 units 301- 350 = 8 units if greater than 350 = 12 units and recheck blood sugar in 2 hours. If blood sugar does not decrease call the physician. Call the physician if blood sugar less than 70. The original date of this order was 2/1/13.</p> <p>Resident #131 had a current, 1/28/13 dated, health care plan problem of diabetes mellitus. One of the approaches for this problem was to administer medications as ordered by the physician. Another approach for this problem was to monitor blood sugars as ordered by the physician.</p> <p>Review of the August and September 2014, Medication Administration Records (MAR) indicated the incorrect amount of sliding scale insulin had been given to Resident #131 on the following dates and times:</p> | | <p>week for the next five months and weekly thereafter tototal 12 months of monitoring.</p> <p>5. Systemic changes will be completed by October 22, 2014.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155258 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/07/2014 | |
|---|--|---|---|--|--|---|--|
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| | <p>August 11, 5:30 p.m., the blood sugar result was 264. 4 units of insulin was documented as having been given, the resident should have received 6 units.</p> <p>August 22, 5:30 p.m., the blood sugar result was 318. 6 units of insulin was documented as having been given, the resident should have received 8 units.</p> <p>August 22, 8:00 p.m., the blood sugar result was 245. 6 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>August 30, 8:00 a.m., the blood sugar result was 225. 2 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>September 4, 12:00 p.m., the blood sugar result was 204. 2 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>September 12, 8:00 p.m., the blood sugar result was 209. 2 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>September 13, 5:30 p.m., the blood sugar result was 176. 4 units of insulin was documented as having been given, the resident should have received 2 units.</p> | | | | | | |

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|--------------------|--|---------------|---|----------------------|
| | <p>September 26, 12:00 p.m., the blood sugar result was 201. 2 units of insulin was documented as having been given, the resident should have received 4 units.</p> <p>Review of the August and September 2014, Medication Administration Records (MAR) indicated the blood sugar was not rechecked and/or the physician was not notified per parameters of physician order for Resident #131 on the following dates and times:</p> <p>August 8, 12:00 p.m., the blood sugar result was 401. The blood sugar was greater than 350 and not rechecked in 2 hours.</p> <p>August 27, 12:00 p.m., the blood sugar result was 386. The blood sugar was greater than 350 and not rechecked in 2 hours.</p> <p>September 23, 8:00 p.m., the blood sugar result was 60. The blood sugar was less than 70 and the physician had not been informed or offered the opportunity to act on the information.</p> <p>During an interview with the Director of Nursing on 10/7/14 at 7:58 a.m., she indicated the incorrect amount of sliding scale coverage was given to Resident</p> | | | |

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| | <p>#131 on 8/11/14, 8/22/14 - two times, 8/30/14, 9/4/14, 9/12/14, 9/13/14, and 9/26/14. She further indicated based on Resident #131's blood sugar results the blood sugar had not been rechecked in 2 hours or the physician informed on 8/8/14, 8/27/14, and 9/23/14.</p> <p>Review of the current, revised 10/2010, facility policy, titled "Nursing Care of the Resident with Diabetes Mellitus," provided by the Administrator on 10/6/14 at 10:22 a.m., included, but was not limited to,</p> <p>"...Glucose Monitoring... ...2. The physician will order the frequency of glucose monitoring. 3. Resident whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation...."</p> <p>3.1-37(a)</p> | | | | | | |