

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: July 15, 16, 17, 18, 19, and 20, 2012</p> <p>Facility Number: 000160 Provider Number: 155258 Aim Number: 100267190</p> <p>Survey Team: Tammy Alley RN TC Toni Maley BSW Donna M. Smith RN (July 15, 16, 17, 18, and 19, 2012) Julie Call RN (July 16, 17, 2012) Ginny Terveer RN (July 16, 17, 2012)</p> <p>Census Bed Type: SNF: 20 SNF/NF: 77 Total: 97</p> <p>Census Payor Type: Medicare: 28 Medicaid: 57 Other: 12 Total: 97</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>Ms. Kim Rhoades Indiana State Department of Health Long Term Care Division 2 N. Meridian St. Indianapolis, IN 46204-3006 August 3, 2012 Dear Ms. Rhoades: Please find enclosed the Plan of Correction to the annual Recertification and State Licensure Survey conducted on July 20, 2012. This letter is to inform you that the plan of correction attached is to serve as Countryside Manor Health &amp; Living Community's credible allegation of compliance. We allege compliance on August 19, 2012. We are requesting a desk review for this plan of correction. If you have any further questions, please do not hesitate to contact me at (765)649-4558. Sincerely, Stephanie Ingram, H.F.A. Administrator This plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Countryside Manor Health and Living Community or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>		

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.

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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Quality review 7/24/12 by Suzanne Williams, RN			

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review, observation and interview, the facility failed to ensure the correct complaint line phone number for the Indiana State Department of Health was posted. The deficient practice had the potential to affect 97 of 97 residents residing in the facility.</p> <p>Findings include:</p> <p>During an interview with the Resident Council President on 7/16/12 at 10:20 a.m., she indicated she did not know how to locate the complaint line number.</p> <p>During an observation on 7/16/12 at 10:56 a.m., the listed phone numbers were on the wall in the main lobby, but the Indiana State Department of</p>	F0156	F156 1. The complaint line phone number for the Indiana State Department of Health has been corrected. 2. Other residents will also be able to view the correct complaint line phone number as needed. 3. The systemic change will be to review the posting on a scheduled basis to ensure the posting is correct. 4. The complaint line phone number posting will be reviewed monthly to ensure compliance. Results of this audit 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 August 19, 2012.	08/19/2012			

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Health number that was posted was a fax number.</p> <p>During interview with the Administrator on 7/17/12 at 1:35 p.m., she indicated the number was a fax number and the complaint hotline number was located in the admission booklet each resident received on admission.</p> <p>3.1-4(j)(3)(A)</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified of weight changes and a lab result for 2 of 3 residents reviewed for physician</p>	F0157	F157 1. Resident #230 no longer resides in this community. The physician for resident #201 has been notified regarding her weight changes and this resident is no longer on daily weights. 1:1	08/19/2012

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>notification in a sample of 3. (Resident # 230 and 201)</p> <p>Findings include:</p> <p>1. The record for Resident # 230 was reviewed on 7/18/12 at 2:50 p.m.</p> <p>The resident was admitted on 7/3/12.</p> <p>A physician order dated 7/4/12 indicated an order for daily weights.</p> <p>A "Weight Variance Report" indicated the following weights: 7/5/12: 146.9 7/6/12: 145.7 7/9/12: 137.7 7/10/12: 139.0</p> <p>A 7/6/12 nutrition assessment indicated the resident's weight was 146 pounds and had no nutritional problems.</p> <p>A 7/16/12 nutritional assessment indicated the residents weight was 138, a weight loss of 6.2 % in the past 10 days.</p> <p>The record lacked physician notification of the weight loss until 7/17/12, when a supplement was ordered.</p>		<p>in-servicing has been provided for the nurse. 2. An audit of residents with physician ordered daily weights has been completed with notification of weight changes out of parameters communicated to the M.D. An audit of residents with labs showing abnormal glucose levels in the absence of a diabetes diagnosis has been completed with notification to the M.D. No other residents were affected. 3. The systemic change includes that physician ordered daily weights and abnormal glucose level lab results without a diabetes diagnosis will be reviewed daily (Monday through Friday) by the unit manager or designee to determine that appropriate MD notification has occurred. Licensed nursing staff will be offered education on notifying physicians of daily weight changes out of ordered parameters and of abnormal glucose level lab results. Newly hired nursing staff will be educated on notification of change. 4. The Director of nursing or designee will review all physician ordered daily weights and abnormal glucose level lab results for residents without a diabetes diagnosis to include notification to MD five times per week for one month, then five times per month for five months, then three times per month for six months to total 12 months of monitoring. Results of these</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Additional information was requested from Unit Manger # 12 on 7/19/12 at 10:46 a.m., regarding the notification of the weight loss prior to 7/17/12.</p> <p>During interview on 7/19/12 at 12:52 p.m., Unit Manger #12 indicated the physician was not notified of the weight loss until 7/17/12 and had not been notified on 7/8/12 when the weight was down.</p> <p>Laboratory results indicated the residents glucose was elevated on the following dates with no documentation of physician notification: 7/5/12: 173 (normal 70-100) 7/7/12: 238 7/9/12: 192 7/13/12: 424</p> <p>On 7/19/12 at 12:52 p.m., during interview, Unit Manager #12 indicated the laboratory reports were faxed to the physician and the laboratory result from 7/14/12 was also faxed to the physician. She indicated she was unsure if the physician was verbally reported the glucose levels. The resident was having low potassium levels and that was being treated.</p> <p>On 7/19/12 at 2:40 p.m., during interview, Unit Manager #12 indicated</p>		<p>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 August 19, 2012.</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>there was no other information regarding the increased blood glucose levels.</p> <p>2. The record for Resident # 201 was reviewed on 7/18/12 at 1:37 p.m.</p> <p>The resident was admitted on 6/21/12 with a diagnoses that included, but were not limited to, congestive heart failure.</p> <p>A physician order dated 6/21/12 indicated the resident was to be weighed daily and the physician was to be notified of a greater than 2 pound weight gain in a day or greater than a 5 pound weight gain in a week.</p> <p>A June 2012 Treatment Administration Record (TAR) indicated the resident weighed 109.1 on 6/29/12 and 113.8 on 6/30/12. No physician notification was located in the record.</p> <p>A July 2012 TAR indicated the following greater than 2 pound weight gain with no physician notification located on the following dates: 7/1/12: 110.2 7/2/12: 112.6 7/13/12: 114.3 7/14/12: 119.8 7/15/12: 116.4</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>7/17/12: 113.8 7/18/12: 117.7 7/19/12: 122.5</p> <p>Additional information was requested from Unit Manager # 12 on 7/19/12 at 10:46 a.m., about the physician being notified of the above weight changes.</p> <p>On 7/19/12 at 2:40 p.m., during interview Unit Manager #12 indicated there was no other information regarding physician notification of the above weight changes.</p> <p>3. A policy titled "Change in a Resident's Condition or Status" was provided by the Director of Nursing on 7/20/12 at 3 p.m., and deemed as current. The policy indicated: "Policy Statement Our facility shall promptly notify the resident, his or her attending physician,...of changes in the resident's medical/mental condition and/or status...1. The nurse supervisor/charge nurse will notify the resident's attending physician...when there has been:...d. A significant change in the resident's physical...condition. e. A need to alter the resident's medical treatment significantly...."</p> <p>3.1-5(a)(2)</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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

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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F0253 SS=C	<p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>Based on observations, interviews, and record review, the facility failed to ensure a clean and sanitary environment for 22 of 34 observed rooms. (Room #'s 239, 217, 236, 232, 220, 219, 224, 242, 238, 233, 237, 240, 222, 303, 335, 244, 338, 318, 207, 214, 202, 218)</p> <p>Findings include:</p> <p>1. Room 224 was observed on 7/16/12 at 8:20 a.m. In the corner of the room behind the entry door, a build up of gray debris was observed. The resident room and bathroom's floor was dull and discolored with scattered areas of gaps containing dark brown to black substance between the gapping tiles.</p> <p>On 7/16/12 at 11:13 a.m. during a family interview, the family member indicated she noticed a big difference between the 2 units. She also indicated she had observed the accumulated debris behind the resident's room door.</p>	F0253	<p>F253 1. Room #224: will be deep-cleaned and the floor will be replaced. Room #220: the over-the-bed light will be fixed, areas of chipped paint behind the chair will be repaired, and the floor will be replaced. Room #238: will be deep-cleaned and the floor will be replaced. Room #240: will be deep-cleaned and the floor will be replaced. Room #222: the shower curtain will be replaced, and the shower area will be emptied of residents' items and stored in a more appropriate place. Room #232: will be deep-cleaned. Room #233: wall paper will be repaired and the floor will be replaced. Room #237: wall paper will be repaired, the window sill will be repaired and the floor will be replaced. Room #242: will be deep-cleaned, the cove base will be repaired and the floor will be replaced. Room #239: will be deep-cleaned, wall will be repaired and the floor will be replaced. Room #236: will be deep-cleaned, re-painted and the floor will be replaced. Room #217: floor will be replaced. Room #219: will be deep-cleaned, the pipe will be repaired, the ceiling fan will be repaired, the ceiling vent will be</p>	08/19/2012

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>2. Room 220 was observed on 7/16/12 at 9:37 a.m. The light cover used by the first bed resident was observed. This light extended over the end of the bed and over her table. One third of the end of this light had various lengths of cracks with the other end having only small cracks. The wall behind the chair in this same area had an irregular area with paint chipped out with a brown base behind the chipped areas visible. The floor was dull and discolored with scattered areas of gaps containing dark brown to black substance between the gapping tiles.</p> <p>3. Room 238 was observed at 7/16/12 at 10:00 a.m. The corners of the bathroom and room had an accumulation of brown and gray debris. The floors in the room and bathroom were dull and discolored.</p> <p>4. Room 240 was observed on 7/16/12 at 10:34 a.m. In this room under the drawers, an accumulation of brown/gray debris was observed in the corners. Loose light gray dust was observed under the resident's bed. In the bathroom, the corners were observed with accumulated gray dust. Under the sink cracked areas were observed in the floor tiles with an accumulation of gray/brown debris</p>		<p>cleaned and the floor will be replaced. Room #303 will be deep-cleaned. Room #335, entry way door will be repaired, bathroom door will be repaired. This room will also be deep-cleaned. Room #344: entry way door trim will be repaired. Room #338: bathroom door will be repaired and this room will be deep-cleaned. Room #318: over-the-bed table and floor will be cleaned. Room #207: door will be repaired. Room #214: bathroom floor and baseboard will be cleaned. Room #202: will be re-painted and deep-cleaned. Room #218: wallpaper will be repaired and room will be re-painted. For any rooms with wallpaper in need of repair; the wallpaper removal and paint will be placed on a schedule for completion. An outside vendor will be assisting the community with replacement of floors. Bids will be obtained and work will be scheduled. 2. Other resident rooms will be reviewed for the areas identified and addressed per schedule and as needed. 3. The systemic change includes that a resident room checklist will be used when cleaning resident rooms. A deep clean checklist will be used with deep cleans for resident rooms. The housekeeping staff will be educated on proper attention to detail when cleaning resident rooms and the deep-clean schedule, along with checklists to</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>with one corner missing a triangular piece of floor tile with debris also accumulated in this area. The bathroom and room floor tiles were dull with areas of thin wavy cracks scattered throughout with an accumulation of dark brown/black accumulation.</p> <p>5. Room 222 was observed on 7/16/12 at 10:53 a.m. In the bathroom the shower area was being used for the resident's storage. The shower curtain covering this area was observed dragging across the floor with a brown discolored area of the shower curtain in contact with the floor.</p> <p>6. Room 232 was observed on 7/16/12 at 2:10 p.m. The bathroom floor was observed with an accumulation of gray loose debris and paper accumulated in the corners of the room. Along the one side of the resident's room scattered loose debris/paper was observed all around the room and under the bed.</p> <p>7. Room 233 was observed on 7/16/12 at 4:28 p.m. In the room the wallpaper was peeling off on both sides of the window with no wallpaper below the window. Scattered black marks were observed across the</p>		<p>be used. 4. Quality improvement audits will be completed by the maintenance director or designee. Audits will be completed five times per week for one month, three times a week for two months, then monthly for the next ten months to total 12 months of monitoring. Schedule of items for repair in resident rooms will be audited three times per month to ensure completion. 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 August 19, 2012.</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>middle of the wall and the bottom of the wall. Patched dry wall around 3 screw sized holes were present. In the bathroom a 9 inch scraped area was observed on the wall opposite the toilet and sink about 6 inches above the cove base. The room and bathroom floors were observed dull and discolored.</p> <p>7. Room 237 was observed on 7/17/12 at 9:25 a.m. At this same time during an interview, Resident #82 pointed out the torn wallpaper around the window. Also an 8 inch strip of trim was observed torn off of the window seal. A 9 inch torn piece of wallpaper was observed below the window seal on one side with a 1 inch piece of loose wallpaper at the seam below the window and above the cove base at the opposite end of the window. The bathroom door was observed with scratches across the bottom of the door with chipped areas of wood on the inside of this bathroom door. His shelf containing his knick-knacks had a layer of loose dirt on it. Also, an accumulation of brown/yellow stain was observed under the drawer/closet area. Throughout the room and bathroom the floor was discolored with loose debris and an accumulation of gray debris in all corners.</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
	<p>8. Room 242 was observed on 7/17/12 at 10:05 a.m. Upon entering the bathroom, a 6 inch piece of cove base was loose at the top and was caved in at the bottom exposing an area of brown/gray debris. In all 4 corners of the bathroom there was a build up of brown/gray debris. The floor in the room and bathroom was dull and discolored with scattered areas of gaps containing dark brown to black substance between the gapping tiles.</p> <p>9. Room 239 was observed on 7/17/12 at 1:46 P.M. The bathroom floor was dull and discolored with a dried, gray-like substance/stain in the corners of this room. A dried spilled dark gray area was observed under the residents bedside table, which was located next to the Bathroom door. Above the bed on the other side of the room, an area above the head of the bed was missing paint with the white dry wall substance visible. The floor area under the closet and drawers was yellow/brown stained along the cove base.</p> <p>10. Room 236 was observed on 7/17/12 at 1:54 p.m. Along the wall next to here recliner, 2 streaks of black marks were observed on the</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>wall and also above her bedside tale behind her butterfly night light. Brown accumulated debris was observed under the set of drawers next to the cove base. Upon entering the resident's bathroom, the bottom 1/3rd of the door was observed with scratches in the door and along the inside of the door. The floor tiles were observed with scattered areas of gaps between various floor tiles with an accumulation of dark brown to black substance observed in these gaps. An accumulation of loose debris was observed behind the toilet.</p> <p>11. Room 217 was observed on 7/17/12 at 2:23 p.m. The floor in the room and the bathroom was discolored and stained throughout, especially around the toilet.</p> <p>12. Room 219 was observed on 7/17/12 at 2:36 p.m. In the bathroom 2 of the 4 corners had a dark brown accumulation of debris. A pipe protruding from the wall next to the toilet had a jagged opening around this pipe. The fan ceiling cover had a triangular shape opening on one side of it. The ceiling vent in the corner of the bathroom had dried orange substance on the one side of the metal vent. The floors in the room and bathroom were dull and</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>discolored with brown/yellow stains around the cove base. Upon opening/closing the room entry door, the door would drag as one would be closing the door midway. This would leave marks on 1 of the 12 inch floor tiles where the door would get caught.</p> <p>13. On 7/19/12 at 1:30 p.m., the Administrator provided the "Housekeeping and Laundry Service Cleaning Schedule." She indicated the current schedule for the residents rooms included, but was not limited to, the floor care. This floor care indicated the first shift was to sweep, mop, and wipe baseboard.</p> <p>14. On 7/16/12 between 8:20 a.m., and 10:45 a.m., the following was observed on the east unit.</p> <p>Room 303 had cob webs in the window sill on the inside.</p> <p>Room 335's entry way door had mars and scuffs along the bottom of the door approximately 12 inches up from the floor. The bathroom door had mars and scuffs approximately 6 inches up from the floor. There was a 3 foot wide by 3 inch scuff of paint on the right side bathroom wall. There were cob webs in the window sill on the inside.</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>Room 344's entry way door trim was pulling away from the door in several places.</p> <p>Room 338's bathroom door had mars and chips along the bottom of the door 18-24 inches up the door. There were cob webs in the window sill.</p> <p>Room 318's floor had dried feeding puddles on the floor on the left side of the bed and dried feeding on the metal base of the over the bed table.</p> <p>15. Room 207: During a 7/16/12, 9:53 a.m. observation, Room 207 was missing coating and finish to the lower portion of the door resulting a marred scared finish. During an interview at the same time, Resident #45, who resided in the room, indicated she found the scared marred finish unattractive. Resident #45 indicated she believed she needed a bathroom with a larger door to accommodate her wheelchair passing in and out of the door without catching and marring the door.</p> <p>16. Room 214:</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>During a 7/16/12, 9:00 a.m. observation of room 214 and Interview with it's Resident #2 , the resident indicated " The floor could use a good scrubbing." The bathroom floor had a filmy residue in the corner and around the baseboard.</p> <p>17. Room 202:</p> <p>During a 7/17/12, 9:48 a.m., observation of room 202 and interview with Resident #89 who resided in the room, the resident indicated the facility did not clean her room as much as she would like. she indicated there was a scuff mark on the wall that needed scrubbed off and the room could use a good dusting. During an observation at the same time, there was several black streaks on the wall below the window. The black streaked scuff marks ran the full length of the window. The chest of drawers and small stand both had light white gray dust all over the top surface.</p> <p>18. Room 218:</p> <p>During a 7/17/12, 1:05 p.m. observation of room 218 and interview with Resident #226, who resided in the room, the resident indicated she had no idea why her</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>room was only half painted and it did not look nice. she also indicated the wall paper was coming loose from the walls. She indicated the room did not have a nice appearance. During an observation at the same time the long wall which went behind the closets was paint half way in cream and 1/2 way in pale yellow. The wall had the appearance that someone had half finished painting it. the line separating the 2 colors was not smooth and straight. It was wavy and uneven. The pale yellow paint was faded and drab. The wall paper around and beside the window was pulling away from the wall.</p> <p>3.1-19(f)</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0309 SS=D	<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 ensure a high glucose level was monitored with follow-up for 1 of 1 resident reviewed for high glucose levels. (Resident # 230)</p> <p>Findings include:</p> <p>The record for Resident # 230 was reviewed on 7/18/12 at 2:50 p.m.</p> <p>Laboratory results indicated the resident's glucose was elevated on the following dates: 7/5/12: 173 (normal 70-100) 7/7/12: 238 7/9/12: 192 7/13/12: 424</p> <p>The record lacked physician notification of the specific glucose levels and any follow-up assessment for the high glucose level between 7/13/12 and 7/17/12.</p>	F0309	<p>F309 1. Resident #230 no longer resides in the community. 2. An audit of residents with an elevated glucose and an absence of a diabetic diagnosis has been completed with notification of abnormal results communicated to the M.D. No other residents were affected. 3. The systemic change includes that elevated glucose results with the absence of a Diabetes diagnosis will be reviewed daily (Monday through Friday) by the unit manager or designee to determine that appropriate MD notification has occurred. Education will be offered to licensed nursing staff that residents with elevated glucose levels per laboratory results who are not diagnosed with Diabetes will be referred to their MD for follow-up. Newly hired nursing staff will be educated on notification of elevated glucose levels with the absence of a diabetic diagnosis. 4. The Director of Nursing or designee will review all abnormal glucose levels in the absence of a Diabetes diagnosis for notification to MD five times per week for one</p>	08/19/2012			

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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>On 7/16/12 the resident went to a physician appointment and returned with orders to add the diagnosis of diabetes mellitus, accuchecks before meals and at bedtime and for Glucophage (anti-diabetic medication) 500 milligrams twice daily and for the resident to see (name of physician) for diabetes.</p> <p>On 7/17/12 the resident saw (name of physician) for diabetes and sliding scale insulin was ordered.</p> <p>A nursing progress note dated 7/17/12 at 6:38 a.m., indicated the resident had returned from (name of hospital) at 9 p.m. The note indicated the resident's blood sugar had been 497 at the hospital and insulin was given. At 9:30 p.m., the resident's blood sugar was 545 and the physician was notified. The blood sugar was rechecked at 10:15 p.m., and was 443. The physician ordered insulin and it was given. The blood sugar was then checked at 3:10 a.m., and was 238.</p> <p>A nursing progress note dated 7/19/12 at 1:08 a.m., indicated the resident's blood sugar was 463 at 8 p.m., and the physician was notified. One hour later the resident's blood sugar was 561 and insulin was given</p>		<p>month, then five times per month for five months, then three times per month for six months to total 12 months of monitoring. Results of these audits will be reported to the monthly Quality Assurance Committee meeting for 12 months and frequency and duration of reviews will be adjusted as needed. 5. Systemic changes will be completed by August 19 th, 2012</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>per the physician's orders.</p> <p>On 7/19/12 at 12:52 p.m., during interview, Unit Manager #12 indicated the laboratory reports were faxed to the physician and the laboratory result from 7/14/12 was also faxed to the physician. She indicated she was unsure if the physician was verbally reported the glucose levels. The resident was having low potassium levels and that was being treated.</p> <p>On 7/19/12 at 2:40 p.m., during interview Unit manager #12 indicated there was no other information regarding the increased blood glucose levels and any follow-up between 7/13/12-7/17/12.</p> <p>3.1-37(a)</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observations, record reviews, and interview, the facility failed to ensure it remained free of a medication error rate of 5% or greater for 6 of 51 opportunities during 4 of 9 nursing staff observed and for 4 of 14 residents observed during medication pass observation. The medication error rate was 11.7%. (Resident #'s 107, 31, 63, and 96) (LPN #'s 1, 2, 3, and 4)</p> <p>Findings include:</p> <p>1. On 7/15/12 at 4:10 p.m., medication pass was observed. LPN #3 indicated Resident #107's blood sugar accucheck was 173 and would require insulin coverage. After preparing 2 units of Novolog Insulin (to control high blood sugar), Resident #107 received her insulin coverage subcutaneously in her right lower abdomen at 4:16 p.m. On 7/15/12 at 5:55 p.m., Resident #107 was observed to receive her meal tray. At this same time during an interview, Resident #107 indicated she had not eaten any snack or other food since receiving her insulin</p>	F0332	<p>F332 1. LPNs #1, #2, #3 &amp; #4 have received 1:1 education regarding correct procedure for medication administration. LPNs #1, #2, #3 &amp; #4 will have medication administration observation to determine compliance with policy. 2. Licensed nursing staff will be observed for medication administration. Any identified issues will be addressed immediately and re-education will be completed. 3. The systemic change includes that education will be provided to licensed nurses and QMAs regarding appropriate medication administration and will include the following: *Insulin types and peak times *Proper eye drop administration *Proper nasal spray administration *Proper preparation of Potassium for administration 4. The Staff Development Coordinator or designee will audit by observation of medication administration on all shifts five times per week for one month, then weekly for one month, then monthly for the next ten months, to total twelve months of monitoring. Any identified concerns from audits will be addressed immediately. Results of these reviews will be</p>	08/19/2012			

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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
	<p>coverage.</p> <p>On 7/19/12 at 4:15 p.m. during an interview, LPN #3 indicated she gave her medications within the time span of 1 hour before or 1 hour after the medication was ordered. She indicated she was not aware the insulin should be given 15 minutes before a meal.</p> <p>On 7/19/12 at 10:10 a.m., Resident #107's medications were reconciled. The resident's diagnoses included, but were not limited to, diabetes mellitus. The signed physician's rewrite orders, undated, indicated the following: The physician's order, originally dated 10/21/11, was Novolog inject subcutaneously every morning and evening per sliding scale; blood sugar 151 to 200 = 2 units. The physician's order, originally dated 10/27/11, was accuchecks twice daily at 7 a.m. and at 4 p.m.</p> <p>The "GERIATRIC DOSAGE HANDBOOK" 12th Edition indicated Novolog should be administered within 15 minutes before a meal.</p> <p>2. On 7/16/12 at 8:31 a.m., medication pass was observed. As LPN #2 prepared Resident #31's oral medications, she was observed to</p>		<p>reported 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 August 19, 2012.</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>place the Klor Con ER (extended release) (to prevent low potassium) tablet into a small amount of water in a medication cup. At this same time during an interview, LPN #2 indicated she had put the Klor Con ER tablet into the water to allow it to dissolve because she could not crush the pill. After preparing the rest of the resident's oral medications, the dissolved tablet was given with the rest of the resident's crushed medications in applesauce, which was watery in appearance.</p> <p>On 7/19/12 at 10:05 a.m., Resident #31's medications were reconciled. The resident's diagnoses included, but were not limited to, hypertension. The signed physician's rewrite orders, dated 6/(unclear)/12, indicated the following: The physician's order, originally dated 09/07/11, was Klor Con tab 20mEq ER take 1 tablet by mouth every 12 hours (9 am and 9 pm).</p> <p>On 7/19/12 at 4:10 p.m. during an interview, Unit Manager #11 indicated the Klor Con should not be dissolved in water prior to be given to the resident. She also indicated one of their drug resources was from "Drugs.com." This same source of information indicated the following</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>information:</p> <p>"Potassium Chloride... Brand Names...Klor-Con...</p> <p>What is potassium chloride?</p> <p>Potassium is a mineral that is found in many foods and is needed for several functions of your body, especially the beating of your heart.</p> <p>Potassium chloride is used to prevent or to treat low blood levels of potassium (hypokalemia). Potassium levels can be low as a result of a disease or from taking certain medicines,...</p> <p>Important information about potassium chloride</p> <p>...Do not crush, chew, break, or suck on an extended-release tablet or capsule. Swallow the pill whole. Breaking or crushing the pill may cause too much of the drug to be released at one time. Sucking on a potassium tablet can irritate your mouth or throat...."</p> <p>3. On 7/18/12 at 11:04 a.m., medication pass was observed. After giving Resident #63 her oral medications, LPN #1 administered</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>the eye medication, Restatis (dry eyes) in each eye. After 50 seconds, the second eye drops Bromday 0.09% (anti-inflammatory) were observed to be administered in each eye.</p> <p>On 7/18/12 at 11:17 a.m. during an interview, LPN #1 indicated she should have waited 5 minutes between the eye drops.</p> <p>On 7/19/12 at 10:00 a.m., Resident #63's medications were reconciled. The resident's diagnoses included, but were not limited to, blindness. The signed physician's rewrite orders, undated, indicated the following: The physician order, originally dated 2/24/12, was Bromday solution 0.09% instill 1 drop in each eye twice daily at 12 p.m. and 8 p.m. The physician order, originally dated 2/02/12, was Restasis emulsion 0.05% instill 1 drop in each eye twice daily at 12 p.m. and 8 p.m.</p> <p>The current source "Drugs.com" indicated the following:</p> <p>"Bromday</p> <p>...Bromday is a nonsteroidal anti-inflammatory drug (NSAID) eye drop. It works by blocking the production of prostaglandin, a</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>substance that causes inflammation (redness, swelling, irritation).</p> <p>...How to use Bromday:</p> <p>...* if you are using another medicine that you put in your eye, use Bromday at least 5 minutes before or after using the other medicine...."</p> <p>4. On 7/19/12 at 9:01 a.m., medication pass was observed. After preparing and giving Resident #96 her oral medications, LPN #4 gave the resident her Flonase (allergic rhinitis) with no instructions being given as the resident sprayed 2 sprays in each nostril. No occlusion of the nostril not being sprayed was completed. After Resident #96 handed the Flonase container back to LPN #4 within a time period of 30 seconds, LPN #4 administered 1 puff of Flovent (bronchodilator), waited 20 seconds, and then, administered the second puff.</p> <p>On 7/19/12 at 9:14 a.m. during an interview, LPN #4 indicated she should have waited 1 minute possibly between the resident's 2 puffs of her inhaler medication.</p> <p>On 7/19/12 at 9:25 a.m., Resident #96's medications were reconciled. The resident's diagnoses included,</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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			
	<p>but were not limited to, bronchitis and allergic rhinitis. The current physician's hospital discharge orders, dated 7/15/12, indicated the following: Fluticasone Propionate (Flovent) 2 puffs 2 times a day; Fluticasone Propionate (Nasal) (Flonase) 1 spray nasally 2 times a day.</p> <p>The "GERIATRIC DOSAGE HANDBOOK" 12th Edition indicated the following:</p> <p>"Fluticasone ...Administration Aerosol inhalation: ...Allow 1 full minute between inhalation... Nasal spray: ...Insert applicator into nostril, keeping bottle upright, and close off the other nostril...."</p> <p>5. The "MEDICATION ADMINISTRATION: GENERAL POLICIES &amp; PROCEDURES" policy was provided by the Administrator on 7/19/12 at 11:05 a.m. This current policy indicated the following:</p> <p>"...PROCEDURE: Preparation: ...2. All medications will be prepared in accordance with manufacturer's guidelines such as proper amount of fluid to mix, specific warnings and</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>cautionary instructions...."</p> <p>The "ADMINISTRATION OF EYE DROPS" policy was provided by the Administrator on 7/19/12 at 11:05 a.m. This current policy indicated the following:</p> <p>"...RECOMMENDED PROTOCOL</p> <p>...16. When multiple eye drop prescriptions are ordered, wait at least 5 minutes between instillation to avoid excessive loss and dilution of the drugs....."</p> <p>The "ADMINISTRATION OF NASAL MEDICATIONS" policy was provided by the Administrator on 7/19/12 at 11:05 a.m. This current policy indicated the following:</p> <p>"RECOMMENDED PROTOCOL</p> <p>...Nasal spray:</p> <p>...2. To prevent air from entering the nasal cavity and to allow the medication to flow properly, occlude one nostril and insert tip of spray bottle into open nostril.</p> <p>3. Instruct resident to inhale and squeeze bottle at the same time.</p> <p>4. Repeat procedure in other nostril.</p> <p>5. Instruct resident to keep head tilted back for 3-5 minutes and</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>breathe slowly through nose. Do not blow nose....."</p> <p>The "ADMINISTRATION OF METERED-DOSE INHALERS" policy was provided by the Administrator on 7/19/12 at 11:05 a.m. This current policy indicated the following:</p> <p>"...RECOMMENDED PROTOCOL</p> <p>...8. Repeat puffs as directed. Wait one minute between puffs....."</p> <p>3.1-25(b)(9) 3.1-48(c)(1)</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0356 SS=C	<p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observations, interview, and record review, the facility failed to ensure the total actual hours of the licensed and non-licensed staff were included and were posted in a timely manner for 5 of 6 days observed</p>	F0356	F356 1. The posted nurse staffing information has been revised to total the number of hours under each category. The posted nurse staffing information will be posted timely on a daily basis. 2. Residents and other	08/19/2012			

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 07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>during the annual survey and to ensure the facility knew the minimum time limit for keeping the posting information. This deficiency had the potential to impact 97 of 97 residents residing in the facility. (July 15, 16, 17, 18, and 19, 2012)</p> <p>Findings include:</p> <p>On 7/15/12 at 3:35 p.m. during the initial tour, the staffing posted at the front entrance was dated 7/13/12 and did not include the total actual hours worked.</p> <p>On 7/16/12 at 8:00 a.m., no staffing information was posted. On this same day at 8:10 a.m., the staffing posting was at the front entrance and did not include the actual total hours worked.</p> <p>On 7/17/12 at 8:05 a.m., the staffing information posted was from the previous day (7/16/12).</p> <p>On 7/18/12 at 8:05 a.m., no staffing was observed posted. On this same day at 9:05 a.m., staffing was posted for 7/18/12 and did not include the total hours actually worked.</p> <p>On 7/19/12 at 7:35 a.m., the staffing information posted was from the</p>		<p>visitors will be able to view the posted nurse staffing timely with the total number of hours under each category listed. 3. The systemic change includes that the posted nurse staffing information has been revised to total the number of hours under each category. This also includes that a designated nurse will post the daily nurse posting prior to the beginning of each day shift. The nurses will be educated on this new systemic change. 4. The Director of Nursing or designee will review the staffing posting five times per week for one month, then weekly for one month, then monthly for the next ten months to total twelve 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. Systematic changes will be completed by August 19, 2012.</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>previous day (7/18/12).</p> <p>On 7/19/12 at 4:24 p.m. during an interview, the Staffing Coordinator indicated she would post the staffing for the day after she arrived and received the census for the day. She also indicated she did not total the actual hours worked and thought the posting information should be kept for about 1 year.</p> <p>3.1-13(a)</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation and interview the facility failed to ensure food was palatable for 9 of 25 residents interviewed regarding food palatability (Residents #45, #55, #2, #89, #107, #13, #201, #82 and #231).</p> <p>Findings Include:</p> <p>During interviews with the following 9 residents, who were identified as interviewable during the stage 1 process, the following questions regarding food satisfaction and palatability were asked:</p> <p>1) Does the food taste good and look appetizing?</p> <p>2) Is the food served at the proper temperature?</p> <p>Resident responses to the questions were as follows:</p> <p>a.) During a 7/16/12, 9:41 a.m., interview Resident #45 indicated: "They serve food that I am not used</p>	F0364	<p>F364 1. Residents #45, #2, #89, #107, #13, #201, #82, #231 will be interviewed regarding their food preferences to include their likes and dis-likes. Resident #55 no longer resides at this facility. 2. Residents will be interviewed regarding their food preferences to include their likes and dis-likes, upon admission and with their quarterly assessment. Any issues identified will be addressed. 3. The systemic change includes that residents will be interviewed regarding their food preferences to include their likes and dis-likes, upon admission and with their quarterly assessment. The systemic change also includes that the cook staff will be educated as to proper cooking methods to ensure tenderness, flavor and consistency of food served. Alternatives will continue to be offered to residents. 4. The dining services director or designee will complete resident satisfaction surveys for a minimum of two residents after each meal, daily (Monday through Friday), for one month, three times per week for one month, twice per week for the next four</p>	08/19/2012			

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>to. Like chopped tatters (potatoes) not mashed. It's food nobody likes." Meat is not tender. Vegetables are not tender either. " Green beans are as long as your finger. That's not what I am used to." "Carrots are so hard you can't bite them. Lots of plates have leftovers." "Sometimes the food is not hot."</p> <p>b.) During a 7/16/12, 8:33 a.m., interview, Resident #55 indicated: "I said I liked boiled eggs and now I have had the same thing for 3 weeks."</p> <p>c.) During a 7/16/12, 9:16 a.m., interview Resident #2 indicated:  " Foods isn't done. Potatoes are raw. There is meat you can't cut with a knife and can't chew."  "Once in awhile food is not hot."</p> <p>d.) During a 7/17/12, 9:56 a.m., Interview Resident #89 indicated:  "Bread with a slice of cheese; that was our sandwich. That is not a</p>		<p>months, and weekly thereafter to total twelve months of monitoring. Meal quality will be audited to include accurate temperature. This audit will be conducted five times per week for one month, three times per week for one month, twice per week for the next four months and weekly thereafter to total twelve 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 August 19, 2012.</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>sandwich."</p> <p>e.) During a 7/16/12, 3:58 p.m. interview Resident #107 indicated:</p> <p>"It's garbage!"</p> <p>"I follow the cart and get my tray so doesn't get cold."</p> <p>f.) During a 7/17/12, 8:42 a.m., interview Resident #13 indicated:</p> <p>The eggs tasted like powered eggs. They forgot the sugar for the cream of wheat.</p> <p>Spare ribs were tough and it was hard to cut the meat off. "The meat is usually hard as a rock and I usually just leave it."</p> <p>g.) During a 7/16/12, 11:05 a.m., interview, Resident #201 indicated:</p> <p>"Sometimes the food is cold before I get to eat it."</p> <p>h.) During a 7/17/12, 9:14 a.m., interview Resident #82 indicated:</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>"Some of the meat I don't like."</p> <p>i.) During a 7/17/12, 9:00 a.m., interview, Resident #231 indicated:</p> <p>The bacon was burnt . The food was no good. Meat was tough. I had a rib the other day and couldn't cut the meat off of it.</p> <p>During a 7/19/12, 12:15 p.m. to 12:40 p.m., observation the regular meatball stroganoff was observed. Some of the meatballs were very dark brown in color. Some residents appeared to have difficulty cutting the meatballs.</p> <p>During a 7/19/12 observation and interview, Resident #231 indicated "The meatballs are tough. I can't eat them." "The food here does not taste good at all. A [fast food] cheeseburger tasted good when my family brought it the other day." Resident #231 left the meat balls uneaten on her plate.</p> <p>During a 7/19/12, 12:30 p.m., observation and interview, Resident #2 indicated the meatballs were tough and she could not eat them. She left the meatballs uneaten on her plate.</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	<p>The meatballs were dark brown and dry in appearance.</p> <p>During a 7/19/12, 12:40 p.m., interview with both of the CO-Dietary Managers the following was indicated:</p> <p>a.) There were two type of meatballs prepared for lunch.</p> <p>b.) The pre-cooked meatballs were a bit brown and difficult for the residents to cut.</p> <p>During a 7/19/12, 12:45 p.m., observation, six tables were observed for uneaten food. Five of six tables were observed to have meatballs left on the finished meal plates.</p> <p>3.1-21(a)(2)</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
F0441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observations, interviews, and record review, the facility failed to</p>	F0441	F441 1. Residents # 56, #115 and #225 no longer reside in the	08/19/2012	

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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>ensure infection control practices were followed related to handwashing while passing meal trays for 1 of 3 staff members (CNA # 6) (Resident #225 and 129) observed for 1 of 1 meal observation with room trays, handwashing and medication handling during medications pass for 2 of 6 LPN's (LPN #4 and LPN #5) (Resident #'s 115 and 96) observed, handwashing during 1 of 1 personal care observations for 3 of 4 CNA's (CNA #'s 7, 8, and 9) (Resident #56) observed, and linen handling for 2 of 4 observations of linen handling for 1 of 3 linen carts in the hallways and for 1 of 1 Laundry Aide (Laundry Aide #10).</p> <p>Findings include:</p> <p>1. On 7/15/12 at 5:31 p.m. during the meal service for the room trays, CNA #6 was observed to handwash for less than 10 seconds. Then, CNA #6 was observed to pass Resident #129's meal tray. Next, after CNA #6 was observed to handwash for less than 5 seconds, she was observed to pass Resident #225's meal tray to his room. Upon returning to the food cart, she was observed to obtain an uncovered glass of milk and take it to Resident #225 in his room. CNA #6 was again observed to handwash for</p>		<p>community. Resident #96 has not had any signs or symptoms of infection requiring antibiotic therapy since survey completion.</p> <p>2. All residents benefit from proper hand-washing, glove use, handling of linens and appropriate handling of medications. 3. The systemic change includes that Nursing staff will be educated on hand washing and glove use. Licensed nursing staff will be offered education on disposal of medications if they are dropped on the med cart or otherwise contaminated. Nursing and laundry staff will be offered education regarding proper handling of linen. Newly hired nurses will receive education for appropriate infection control practice with hand washing, glove use, and disposal of medications if they become contaminated. In addition, all newly hired nursing and laundry personnel will receive education on proper handling of linens. 4. The Director of Nursing or designee will audit through direct observations on infection control practices as related to hand washing, glove use and disposal of medications if they are dropped on the med cart, on all shifts five times per week for one month, then five times per month for five months, then three times per month for six months to total 12 months of monitoring. The Staff Development Coordinator or designee will audit through direct observations of</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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>less than 5 seconds as she continued to pass the remaining room meal trays.</p> <p>2. During medication pass, the following was observed:</p> <p>a.) On 7/15/12 at 5:16 p.m. during medication pass, Resident #115's nebulizer treatment was observed. In preparation for Resident #115's nebulizer treatment, LPN #5 was observed to put the blood pressure cuff on the resident's arm and the oxygen saturation monitor on her finger. LPN #5 then handwashed for 12 seconds, turned the water off with her wet hand, and then, dried her hands. Next, LPN #5 was observed to assess the resident's lung sounds. After preparing and giving the resident her breathing mouthpiece with the medication and starting the nebulizer treatment, LPN #5 was observed to handwash for less than 5 seconds, turned the water off with her wet hand, and then, dried her hands. She proceeded to reassess the resident's lung sounds and radial pulse as the nebulizer treatment was completed.</p> <p>On 7/18/12 at 8:13 a.m. during an interview, LPN #5 indicated one should handwash for 20 seconds, dry</p>		<p>proper linen handling five times per week for one month, then five times per month for five months, then three times per month for six months 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 August 19, 2012.</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>your hands, and then use a different paper towel to turn off the water.</p> <p>b.) On 7/19/12 at 9:01 a.m. during medication pass, LPN #4 was observed to prepare Resident #96's oral medications. While obtaining these oral medications, 1 of the pills dropped on the top of the medication counter top. LPN #4 was observed to pick the pill up with her fingers and place it with the rest of the resident's oral medications. She then administered these oral medications to the resident and returned back to the medication cart. No handwashing or handgel use was observed as LPN #4 proceeded to set up the next resident's medications.</p> <p>On 7/19/12 at 9:14 a.m. during an interview, LPN #4 indicated she should had thrown the pill dropped on the top of the medication cart away and obtained a new pill.</p> <p>3. On 7/18/12 at 3:02 a.m., Resident #56's personal care was observed. The following was observed: After CNA #7 was observed to assist with the Hoyer lift transfer of the resident from her wheelchair to the bed, she left the room with no handwashing or hand gel use. CNA #7 was observed to resume passing ice water to the rooms.</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
--------------------	--	---------------	---	----------------------

	<p>During the resident's personal care, CNA #9 was observed to assist to roll and undress the resident. CNA #9 was then observed to remove her gloves and left the resident's room returning with more washcloths. Next, during the resident's rectal care, CNA #8 with gloved hands cleansed Resident #'s 56, who had been incontinent of soft, dark brown bowel movement. After the care was completed, CNA #8 with the same gloves was observed to redress, reposition the resident in bed and give her her call light before her gloves were removed and handwashed. At this same time during an interview, CNA #8 indicated one should handwash when one enters and one exits a resident's room and after resident care.</p> <p>4. On 7/15/12 at 3:35 p.m. during the initial tour with the laundry room door open, Laundry Aide #10 was observed folding clean linen. She was observed to handle a gown over her shoulder and under her 1 arm before placing the gown up against her uniform as she folded it and placed it on the folding table. She was observed to fold a second gown and a full sheet in the same manner placing both on the clean linen table. At this same time during an interview,</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>Laundry Aide indicated she was presently folding clean clothes.</p> <p>On 7/15/12 at 6:00 p.m. during an interview, Laundry Aide #10 indicated she would wear a covering when sorting soiled clothing with no information related to folding the clothes next to her uniform.</p> <p>On 7/18/12 at 1:55 p.m., the linen cart in hallway (back) was observed with the cover of the linen cart halfway up exposing the clean linen on the 2 bottom shelves.</p> <p>5. The "Handwashing/Hand Hygiene" policy was provided by the Administrator on 7/19/12 at 2:45 p.m. This current policy indicated the following:</p> <p>"...5. Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:</p> <p>...c. Before and after direct resident contact...</p> <p>g. Before and after assisting a resident with meals;</p> <p>h. Before and after assisting a resident with personal care...</p> <p>...l. Upon and after coming in contact</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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>with a resident's intact skin,...</p> <p>...q. After contact with a resident's mucous membranes and body fluids or excretions;</p> <p>...7. Hand hygiene is always the final step after removing and disposing of personal protective equipment.</p> <p>8. The use of gloves does not replace handwashing/hand hygiene...</p> <p>...Procedure Washing Hands</p> <p>...2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least fifteen (15) seconds...</p> <p>3. Rinse hands thoroughly under running water...."</p> <p>The "Standard Precautions" policy was provided by the Administrator on 7/19/12 at 2:45 p.m. This current policy indicated the following:</p> <p>"...Standard precautions include the following practices:</p> <p>...2. Gloves</p> <p>...g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments.</p> <p>The "Departmental (Environmental Services - Laundry and Linen" policy was provided by the Administrator on 7/19/12 at 2:45 p.m. This current policy indicated the following:</p> <p>" Purpose The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen.</p> <p>...1. Do not allow linen, clean or soiled, to touch clothing or uniform...."</p> <p>The "MEDICATION ADMINISTRATION: GENERAL POLICIES &amp; PROCEDURES" policy was provided by the Administrator on 7/19/12 at 11:05 a.m. This current policy indicated the following:</p> <p>"...Administration:</p> <p>..15. Hands shall be washed after a med pass is completed with one resident and before commencing a med pass with the next resident....."</p> <p>3.1-18(l)</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	3.1-19(g)(1)			

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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0456 SS=E	<p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>Based on record review, observation and interview, the facility failed to ensure resident care equipment was clean and in good repair for 4 of 40 residents reviewed for condition of care equipment. (Resident # 12, # 80, # 84, and # 45)</p> <p>Findings include:</p> <p>1. On 7/15/12 at 3:44 p.m., Resident # 12 was in the dining room. His gastrostomy feeding pump had a large amount of dried feeding on the base of the pump pole.</p> <p>On 07/16/2012 at 10:47 a.m., Resident # 12's wheel chair has dried feeding on the metal bars at the seat, under the seat and on the small wheels. The large wheels had a build up of dust and some splatters of feeding. The resident gastrostomy feeding pump pole had dried feeding splattered on the base and the pump had runs of dried feeding on the back and the front.</p> <p>A wheelchair cleaning schedule was provided by the Director of Nursing on</p>	F0456	<p>F456 1. Resident #12's gastrostomy feeding pump has been cleaned. His wheelchair has also been cleaned. Resident #80's wheelchair arms have been repaired. Resident #84's wheelchair arms have been repaired. Resident #45's wheelchair has been repaired to include both arm rests and the missing side. 2. Other wheelchairs and g-tube poles will be observed and any issues identified will be corrected. 3. The systemic change includes that the wheelchair schedule has been revised and g-tube poles have been added to the cleaning schedule. The systemic change also includes that education will be provided to nursing staff regarding revised schedule for cleaning of wheelchairs and schedule for g-tube poles. Nursing staff will also be educated to notify maintenance team of any areas that require repair with regards to wheelchairs. 4. Unit manager or designee will audit via completion of wheelchair cleaning and g-tube pole cleaning schedule. These audits will be completed five times per week for one month, then three times per week for one month, then one time per week</p>	08/19/2012

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  07/20/2012
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	
	<p>7/20/12 at 3 p.m., indicated "...Chores: Wash all wheel chairs..."</p> <p>2. On 7/17/12 at 2:03 p.m., Resident #80's wheelchair (w/c) was observed. Her right arm w/c was observed with cracked vinyl covering with the lining around the side seams visible. Her left arm w/c was also observed with cracked vinyl covering with lining visible around the seams of the first 1/3rd of the w/c arm.</p> <p>3. On 7/16/12 at 2:10 p.m., Resident #84's wheelchair (w/c) was observed. Both w/c arms were observed with the vinyl covering peeling/flaking off around the seams and to the middle of the w/c arms.</p> <p>4.) During a 7/16/12, 9:53 a.m. observation, Resident #45 had tears in both the right and left wheelchair arm rests and the right side metal panel which included the wheelchair was missing. During an interview at the same time, Resident #45 indicated she would like the missing</p>		<p>for five months, then twice per month for six months 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 August 19, 2012.</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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	side to the wheelchair replaced. 3.1-19(bb)			

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  07/20/2012	
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
F0465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORT ABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observations and interviews, the facility failed to ensure medication supply rooms were clean and sanitary for 2 of 2 medications rooms observed. (East Hall and West Hall)</p> <p>Findings include:</p> <p>1. On 7/15/12 at 5pm, the West Hall medication room was observed. The floor was observed with general debris over the entire floor. This general debris also included a covered lancet, a piece of a ballpoint spring, and several cut off black "keys" from the locked medication drug box. The refrigerator containing the refrigerated locked medication box was observed with the freezer 2/3rds covered with ice. At this same time during an interview, LPN #13 indicated she did not know how often the medication room was swept and indicated the room could use it.</p> <p>2. On 7/19/12 at 9:00 a.m., the East Hall medication room was observed. The corner of the room behind the entry door and under the refrigerator</p>	F0465	<p>F465 1. West hall medication room and east hall medication room have been deep-cleaned and both refrigerators have been de-iced. 2. Both medication storage areas will be maintained per the cleaning schedule. The refrigerators will be de-iced quarterly. 3. The systemic change is that nursing staff and housekeeping staff will be educated regarding medication rooms per the cleaning schedule to include proper cleanliness and de-icing of the refrigerators. 4. Maintenance Director and unit manager or designee(s) will audit the medication room per cleaning schedule, three times per week for one month, then two times per week for one month, then one time per week for the next ten months 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 August 19, 2012.</p>	08/19/2012			

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  07/20/2012
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>was observed with dust debris. The refrigerator's freezer was observed the freezer filled with a build-up of ice and contained the refrigerated locked medication box. Unit Manager #12 indicated the refrigerator needed to be defrosted. She also indicated she thought the room had been swept in the past 2 days.</p> <p>3.1-19(f)</p>			