

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 05/22/2014
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016
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F000000	<p>This visit was for the Investigation of Complaint IN00149567.</p> <p>Complaint IN00149567- Substantiated- Federal deficiencies related to allegations are cited at F314 and F514.</p> <p>Survey dates: May 21 and 22, 2014</p> <p>Facility number: 000160 Provider number: 155258 AIM number: 100267190</p> <p>Survey team: Shelley Reed, RN, TC</p> <p>Census bed type: SN: 19 SNF/NF: 73 Total: 92</p> <p>Census payor type: Medicare: 25 Medicaid: 50 Other: 17 Total: 92</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000314 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, interview and record review, the facility failed to implement interventions to reduce the risk of developing a pressure ulcer/skin breakdown following an assessment for 1 of 4 residents reviewed for skin issues. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident (C) was reviewed on 5/21/14 at 3:30 p.m. with an admission date of 5/16/14. Diagnoses for the resident included, but were not limited to, lumbar surgery, chronic kidney disease, cardiovascular disease, spinal stenosis and pain.</p>	F000314	<p>This plan of correction is to serve as Countryside ManorHealth and Living Community's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute anadmission by Countryside Manor Health and Living Community or its managementcompany that the allegations contained in the survey report is a true andaccurate portrayal of the provision of nursing care and other services in thisfacility. Nor does this submission constitute an agreement or admission of thesurvey allegations.</p>	06/04/2014			

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	<p>During an interview on 5/21/14 at 3:20 p.m., Resident (C) indicated she was recently admitted to the facility following surgery. She was currently receiving therapy to improve walking and strength. She indicated she had been sitting in a wheelchair more than normal and had developed some sores on her bottom that were painful.</p> <p>Review of a current health plan, dated 5/20/14, indicated the resident had a lumbar wound that measured 13 cm with 11 Steri-Strips. Resident (C) was also receiving anticoagulant therapy. No additional skin risk was indicated.</p> <p>During review of an observation report, dated 5/20/14 at 3:20 a.m., Resident (C) was identified with the following risk factors: potential for increase in friction and shearing, exposure of skin to urinary incontinence, fecal incontinence, wound exudates or perspiration. The skin assessment noted a surgical wound related to spinal surgery. The overall skin condition indicated "redness to gluts, two small open areas present".</p> <p>During an interview on 5/22/14 at 10:40 a.m., the Director of Nursing (DoN) was asked to provide additional information related to the skin assessment. She indicated no other information was</p>		<p>F314</p> <ol style="list-style-type: none"> 1. Resident #C currently has interventions in place to reduce the risk of developing a pressure ulcer/skin breakdown. Resident #C has a treatment order in place to that skin area. Resident #C also has currently has a pressure reducing cushion in her wheelchair. 2. Other residents who were at risk of developing a pressure ulcer/skin breakdown were reviewed for preventive measures. Preventive measures were evaluated to ensure that the facility has interventions in place to reduce the risk of developing a pressure ulcer/skin breakdown. 3. The systemic change will be that staff will be educated on implementation of interventions to reduce the risk of developing a pressure ulcer/skin breakdown for residents at risk for skin breakdown. Skin is assessed weekly by the nurse. 4. The Director of Nursing or designee will audit residents weekly 	

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	<p>available. She indicated the nurse identified the two areas of concern and did not document any additional information. She indicated the wound had since been identified as a non-pressure area because the edges were irregular.</p> <p>During observation on 5/22/14 at 10:50 a.m. with the DoN and LPN #1, Resident (C) was noted to have an open, irregular area to the left inside of her buttocks. The area was covered with cream. Resident (C) indicated the area was sore and a new cushion had been provided to her.</p> <p>During review of an observation report, dated 5/22/14 at 10:39 a.m., Resident (C) was noted to have an area to her left gluteal region. The area measured 1.4 cm x 1.2/1.7 cm x 1.0 cm. The character of the wound bed contained granulation with no exudates. The current treatment was Dermaseptine to gluteal area twice daily, turn and reposition every 2 hours and provide a cushion in wheelchair seat.</p> <p>This Federal tag relates to Complaint IN00149567.</p> <p>3.1-40(a)(2)</p>		<p>skin observations to ensure that if areas are identified, that interventions are put into place to reduce the risk of developing a pressure ulcer/skin breakdown. This audit will be completed weekly for six months; then, monthly for the next six months to total 12 months of monitoring.</p> <p>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.</p> <p>5. Systemic changes will be completed by June 4, 2014.</p>		

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurately documented for 1 of 4 residents reviewed for complete and accurate clinical record documentation in a sample of 4. (Resident B)</p> <p>Findings include:</p> <p>The clinical record for Resident (B) was reviewed on 5/21/14 at 11:00 a.m. Diagnoses for the resident included, but were not limited to, leukocytosis, chronic pain, abdominal aneurysm repair and above knee amputation. Resident (B) was receiving Lovenox (anticoagulant medication) injections twice daily in the abdomen and Coumadin (anticoagulant medication) orally.</p>	F000514	<p>F514</p> <p>1. Resident #D is no longer here at this community.</p> <p>2. Other residents' clinical records were reviewed for complete and accurate documentation.</p> <p>3. The systemic change includes that the nurses will be educated that documentation must accurately describe our residents' current condition to include identification of skin concerns and ongoing assessments. Residents will be reviewed upon admission, with significant change or new skin condition daily to ensure that the documentation is complete and accurate.</p> <p>4. The Director of nursing or designee will complete a random</p>	06/04/2014			

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	<p>A nursing note entry, dated 5/19/14 at 3:36 a.m., indicated "writer performing RTN [routine treatment] patient care et noted several issues. During drsg change to LLQ [left lower quadrant] writer noted previous drsg saturated c [with] BRB [bright red blood] et area cont to actively bleed in moderate amts."</p> <p>A physician's order, dated 5/17/14 at 4:42 p.m., indicated a new order for Bacitracin [topical antibiotic] 500unit/gram to be applied to abdominal area and to be covered with Telfa (antimicrobial non-stick pad) then secured with tape. The treatment was to be done twice daily.</p> <p>A full clinical documentation report, dated 5/17/14 at 12:22 a.m., indicated the abdomen had active bowel sounds and the skin was dry and warm. No additional information was noted related to the skin.</p> <p>A full clinical documentation report, dated 5/17/14 at 5:03 p.m., indicated Resident (B)'s abdomen had diminished, but active bowel sounds. The status of the skin noted cool and dry. The peri area was noted to have redness.</p> <p>The Treatment Administration Record (TAR) indicated the abdominal dressing</p>		<p>audit of residents to ensure that documentation is complete for those records. This audit will be completed five times per week for one month and weekly thereafter for five months; then, monthly for the next five months to total 12 months of monitoring.</p> <p>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.</p> <p>5. Systemic changes will be completed by June 4, 2014.</p>	

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	<p>change was done once on 5/17/14 and once on 5/18/14. The resident was sent to the hospital prior to next treatment.</p> <p>The clinical record lacked any entries related to the size of the wound, type of wound or location of the wound.</p> <p>During an interview on 5/22/14 at 10:40 a.m., the DoN indicated the wound to the abdomen was caused by Lovenox injections, but no additional documentation related to skin assessments or nursing notes were provided.</p> <p>This Federal tag relates to Complaint IN149567.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				