

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 09/27/2013
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 205 MARINE DR ANDERSON, IN 46016
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: September 23, 24, 25, 26, 27, 2013</p> <p>Facility number: 000160 Provider number: 155258 AIM number: 100267190</p> <p>Survey team: Karen Lewis, RN, TC Ginger McNamee, RN Jason Mench, RN Betty Retherford, RN (9/24, 9/25, 9/26, 9/27/13)</p> <p>Census bed type: SNF: 21 SNF/NF: 73 Total: 94</p> <p>Census payor type: Medicare: 24 Medicaid: 55 Other: 15 Total: 94</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Qulaity review completed by Debora</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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	Barth, RN.			
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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review, observation, and interview, the facility failed to ensure use of over-the-bed lights were accessible for 3 of 4 residents reviewed for accommodation of needs. (Residents #'s 240, 235, and 238)</p> <p>Findings include:</p> <p>1.) During an observation on 9/24/13 at 9:40 a.m., the string on the Resident 240's over the bed light was only approximately 2 feet long and could not be reached when the resident was lying in bed. The cord was not long enough to be tied to the siderail or placed on the head of the bed.</p> <p>The clinical record for Resident #240 reviewed on 9/26/13 at 10:55 a.m.</p> <p>Diagnoses for Resident #240 included, but were not limited to, multiple sclerosis, muscle weakness, difficulty in walking, and depressive</p>	F000246	F246 1. Resident #240, resident # 235 and resident #238's bed light cords were corrected and are now long enough for the residents to use. 2. Other residents bed light cords were also checked and adjusted/corrected as needed. 3. The systemic change will be that all resident bed light cords will be checked by the Maintenance Director or designee on a quarterly basis (this will be added to the preventive maintenance program). 4. The resident bed light cords will be audited monthly for the next six months and quarterly thereafter. 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 October 18, 2013	10/18/2013	

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	<p>disorder.</p> <p>A 9/18/13 health care plan for Resident #240 indicated she was alert and oriented and preferred to engage in self directed activities such as reading, watching television, and talking on the telephone. One approach for this problem was for the staff to keep personal items and frequently used items in reach.</p> <p>Resident #240 was interviewed on 9/24/13 at 9:40 a.m. She indicated she was unable to reach the string on the light above her bed. She indicated she would like to have the string tied to the siderail of the bed so she could turn the light on and off while in bed.</p> <p>LPN #1 was interviewed on 9/24/13 at 9:50 a.m. and notified of the resident's need for a longer string on her over the bed light. He indicated he would contact the appropriate staff and resolve the issue.</p> <p>2.) During an observation on 9/24/2013 at 10:15 a.m., the string on Resident #235's over the bed light was noted to be approximately 20 inches long and could not be reached without getting out of bed and standing up.</p>						

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	<p>The clinical record for Resident #235 was reviewed on 9/25/13 at 1 p.m.</p> <p>Diagnoses for Resident #235 included, but were not limited to Parkinson's disease, debility, and depressive disorder.</p> <p>An admission Minimum Data Set assessment, dated 9/13/13, indicated the resident was not cognitively impaired and was unable to ambulate.</p> <p>A health care plan problem, dated 9/9/13, indicated the resident preferred to engage in self directed activities such as reading, watching television, and talking on the telephone. One approach for this problem was for the staff to keep personal items and frequently used items in reach.</p> <p>Resident #235 was interviewed on 09/24/2013 10:05 a.m. Resident #235 indicated he would like to be able to turn his over the bed light on and off by himself when he was in bed. He indicated he was unable to do so because the string was not long enough for him to reach while in bed.</p> <p>3.) During an observation on 9/24/13</p>						

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	<p>at 10:40 a.m., the string on Resident #238's over the bed light was only approximately two inches long. The string could not be reached unless you were standing up near the head of the bed.</p> <p>The clinical record for Resident #238 was reviewed on 9/25/13 at 1:50 p.m.</p> <p>Diagnoses for Resident #238 included, but were not limited to, asthma, chronic pain, muscle weakness, and depressive disorder.</p> <p>A 9/23/13 health care plan for Resident #238 indicated she was alert and oriented and preferred to engage in self directed activities such as reading, watching television, and talking on the telephone. One approach for this problem was for the staff to keep personal items and frequently used items in reach.</p> <p>Resident #238 was interviewed on 9/24/13 at 10:40 a.m. Resident #238 indicated she wanted a longer string on her over the bed light so she could turn it on and off when in bed. She indicated she had been admitted less than a week ago and had told several staff (not sure who they were) she needed a longer string. She indicated the staff indicated they would fix the</p>				

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	<p>problem, but it had not been fixed yet.</p> <p>4.) The Administrator was interviewed on 9/24/13 at 3:10 p.m. Additional information was requested related to the lack of over the bed lighting accessibility for Resident #'s 240, 235, and 238. The administrator indicated she would have maintenance do a 100% audit and correct these residents' light strings and any others that needed to be fixed.</p> <p>The Maintenance Supervisor was interviewed on 9/26/13 at 10:00 a.m. He indicated he would fix any light string that needed to be fixed any time the staff made him aware of the issue. He indicated he had an area on the computers at the nursing station where staff could enter repair requests for him, but he had not received any for the previously noted rooms prior to 9/24/13.</p> <p>3.1-3(v)(1)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview and record review, the facility failed to follow physician's orders regarding urinary catheter size for 1 of 2 residents reviewed for urinary catheter use. (Resident # 59)</p> <p>Findings include:</p> <p>The clinical record for Resident #59 was reviewed on 9/25/13 at 12:35 p.m.</p> <p>Diagnoses for Resident #59 included, but were not limited to, diabetes mellitus, hypertension, and urinary retention.</p> <p>A physician order, dated 9/21/13, indicated Resident #59 was to have a Foley catheter anchored one time. No size was indicated for the catheter or the bulb.</p>	F000315	<p>F315 1. The order for resident #59's catheter was clarified to accurately reflect the type of catheter that this resident has in place. 2. Other residents with catheters will be identified and their orders will be checked for accuracy and clarified as needed per MD orders. 3. The systemic change includes that nurses will be educated regarding accuracy of catheter orders to accurately reflect the type of catheter that the resident has in place. 4. The Director of nursing or designee will review all catheter orders for residents with catheters weekly for the next month and monthly thereafter to determine catheter orders are accurate. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. 5. Systemic changes will be completed by October 18, 2013</p>	10/18/2013			

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	<p>A nurse's note, dated 9/21/13 at 10:08 a.m., indicated a 16 French, 30 cc bulb catheter was anchored.</p> <p>A physician order, dated 9/23/13, indicated Resident #59 was to have an 18 French with 30 cc balloon indwelling Foley catheter.</p> <p>During an interview with LPN #3 and the Director of Nursing on 9/26/13 at 2: 25 p.m., LPN #3 indicated she entered the urinary catheter orders into the computer for Resident #59. She further indicated she should have had the orders clarified. LPN #3 indicated a 16 French Foley catheter with 30 cc balloon was still in place for the resident.</p> <p>3.1-41(a)(1)</p>			

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F000329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to withhold a medication per physician ordered parameters for 1 of 5 residents reviewed for unnecessary mediations. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 9/25/13 at 2:52 p.m.</p>	F000329	<p>F329 1. A medication error report was completed for resident #14 and MD and family were notified.</p> <p>2. Other residents with blood pressure parameters will be audited to ensure that their parameters were followed. Any issues found for other residents with blood pressure parameters will be corrected. 3. The systemic change includes that nurses will be educated on blood pressure parameters ordered by the MD and holding medication when it is appropriate. 4. Residents with blood pressure</p>	10/18/2013			

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	<p>Diagnoses for Resident #14 included, but were not limited to, diabetes mellitus, hypertension, and pain.</p> <p>Current physician orders included the following:</p> <p>Hydralazine (a blood pressure medication) 25 milligrams (mg) 1 tablet by mouth three times a day. Hold the medication for a systolic blood pressure less than 110. The start date of this order was 3/17/13.</p> <p>Review of the August and September 2013, Medication Administration Records indicated the following:</p> <p>August 2, 1:00 p.m., the blood pressure result was 102/53, 25 milligrams (mgs) of hydralazine were documented as having been given. The medication should have been held.</p> <p>August 3, 8:00 p.m., the blood pressure result was 98/76, 25 mgs of hydralazine were documented as having been given. The medication should have been held.</p> <p>August 10, 8:00 p.m., the blood pressure result was 96/43, 25 mgs of hydralazine were documented as having been given. The medication</p>		<p>parameters will be audited for accuracy of medication administration 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. Results of these audits will be reviewed at the monthly facility Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. 5. Systemic changes will be completed by October 18, 2013</p>		

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	<p>should have been held.</p> <p>September 7, 8:00 a.m., the blood pressure result was 108/83, 25 mgs of hydralazine were documented as having been given. The medication should have been held.</p> <p>September 18, 8:00 p.m., the blood pressure result was 104/62, 25 mgs of hydralazine were documented as having been given. The mediation should have been held.</p> <p>During an interview with LPN #4 and the Director of Nursing on 9/26/13 at 2:53 p.m., LPN #4 indicated Resident #14 had been given hydralazine 25 milligrams and the medication should have been held per physician ordered parameters on 8/2/13, 8/3/13, 8/10/13, 9/7/13, and 9/18/13.</p> <p>3.1-48(b)(2)</p>				

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on interview and record review, the facility failed to ensure the Consultant Pharmacist identified a medication being given outside the physician ordered parameter or medication orders with the potential to exceed the daily maximum dose for a drug for 1 of 5 residents reviewed for unnecessary medications. (Resident #14)</p> <p>Findings include:</p> <p>The clinical record for Resident #14 was reviewed on 9/25/13 at 2:52 p.m.</p> <p>Diagnoses for Resident #14 included, but were not limited to, diabetes mellitus, hypertension, and pain.</p> <p>Current physician orders included the following:</p> <p>Hydralazine (a blood pressure medication) 25 milligrams (mg) 1 tablet by mouth three times a day.</p>	F000428	<p>F428 1. The drug regimen for resident #14 was reviewed by the Pharmacist and appropriate adjustments to this resident's blood pressure medication with parameter orders and acetaminophen- containing medication were made and approved via MD order. 2. Other residents with blood pressure medication with parameter orders and acetaminophen-containing medications were reviewed by the Pharmacist and appropriate adjustments to their medication regimens were made and approved via MD order. 3. The systemic change includes that the consulting Pharmacist will review all residents' blood pressure medication with parameter orders and acetaminophen-containing medication regimens with appropriate recommendations to the MD as needed during their monthly review. Education will be offered to licensed nurses to hold blood pressure medication as needed according to blood pressure parameter orders. 4.</p>	10/18/2013			

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	<p>Hold the medication for a systolic blood pressure less than 110. The start date of this order was 3/17/13.</p> <p>Review of the August and September 2013, Medication Administration Records indicated the following:</p> <p>August 2, 1:00 p.m., the blood pressure result was 102/53, 25 milligrams (mgs) of hydralazine were documented as having been given. The medication should have been held.</p> <p>August 3, 8:00 p.m., the blood pressure result was 98/76, 25 mgs of hydralazine were documented as having been given. The medication should have been held.</p> <p>August 10, 8:00 p.m., the blood pressure result was 96/43, 25 mgs of hydralazine were documented as having been given. The medication should have been held.</p> <p>September 7, 8:00 a.m., the blood pressure result was 108/83, 25 mgs of hydralazine were documented as having been given. The medication should have been held.</p> <p>September 18, 8:00 p.m., the blood pressure result was 104/62, 25 mgs</p>		<p>Residents with blood pressure parameters will be audited for accuracy of medication administration 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. Pharmacy recommendations regarding acetaminophen containing medications will be audited monthly by the DON or designee to ensure recommendations are followed through as needed with the resident's MD. Results of these audits will be reported to the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed. 5. Systemic changes will be completed by October 18, 2013.</p>				

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	<p>of hydralazine were documented as having been given. The mediation should have been held.</p> <p>During an interview with LPN #4 and the Director of Nursing on 9/26/13 at 2:53 p.m., LPN #4 indicated Resident #14 had been given hydralazine 25 milligrams and the medication should have been held per physician ordered parameters on 8/2/13, 8/3/13, 8/10/13, 9/7/13, and 9/18/13.</p> <p>Resident #14 had the following additional orders:</p> <p>Hydrocodone-acetaminophen (a pain medication) 10-325 mg 1 tablet by mouth three times a day as needed for moderate to severe pain. The start date of this order was 1/31/13.</p> <p>Acetaminophen (a pain medication) 325 mg 2 tablets (650 mg) by mouth every 4 hours as needed for mild pain. The start date of this order was 6/11/13.</p> <p>Acetaminophen (a pain medication) 325 mg 2 tablets (650 mg) by mouth every 4 hours as needed for a temperature greater than 100.4 degrees. The start date of this order was 6/11/13.</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 09/27/2013
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>The clinical record indicated the pharmacist reviewed the physician's orders in July, August, and September of 2013. No recommendations were made related to the resident receiving the hydralazine when the medication should have been held or exceeding the maximum daily recommended dose of acetaminophen.</p> <p>The resident had the potential to receive 8,775 mg of acetaminophen a day. The "2010 Nursing Spectrum Drug Handbook" indicated 4,000 mg as the maximum dose of acetaminophen in a day.</p> <p>During an interview with the Director of Nursing (DoN) on 9/27/13 at 8:07 a.m., additional information was requested related to the pharmacy consultant's reports and lack of recommendations related to the acetaminophen orders.</p> <p>The facility failed to provide any additional information as of exit on 9/27/13.</p> <p>3.1-25(i)</p>				