

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 07/25/2016
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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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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00204669 and IN00205639.</p> <p>Complaint IN00204669 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F314.</p> <p>Complaint IN00205639 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F314.</p> <p>Survey dates: July 21, 22 and 25, 2016</p> <p>Facility number: 000160 Provider number: 155258 AIM number: 100267190</p> <p>Census bed type: SNF: 8 SNF/NF: 86 Total: 94</p> <p>Census payor type: Medicare: 16 Medicaid: 66 Other: 12 Total: 94</p> <p>Sample: 9</p>	F 0000		
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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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F 0282 SS=D Bldg. 00	<p>These deficiencies reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed on July 27, 2016 by 17934.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to follow the physician's orders and care plan interventions for 3 of 9 residents whose care plans were reviewed. (Resident's B, H and I)</p> <p>Findings include:</p> <p>1. The clinical record of Resident I was reviewed on 7/22/16 at 10:20 a.m. Diagnoses for the resident included, but</p>	F 0282	<p>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</p>	08/02/2016

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	<p>were not limited to, Parkinson's disease, diabetes mellitus, pressure ulcer of right buttock-stage 2, hypertension, kidney failure and dysphagia.</p> <p>A review of Resident I's Minimum Data Set (MDS) Quarterly Review dated 5/12/16, indicated the resident was severely cognitively impaired and required extensive assistance and two plus person physical assistance with bed mobility and transfers.</p> <p>Review of a Skin Condition Assessment dated 3/31/16, Resident I was noted to have an abrasion to the right outer gluteal area. The area measured 1.8 cm x 0.5 cm. The area was obtained in the facility. The area was noted as healed on 4/8/16.</p> <p>Review of an Event Report for Resident I dated 6/1/16, an open area to the left gluteal area was noted. The Nurse Practitioner was notified and gave new orders for Santyl (wound ointment) 250 unit/gram nickel sized amount to the wound and then cover with Mepilex (foam dressing), change daily and as needed.</p> <p>On 6/2/16, a Skin Condition Assessment indicated a "shearing" on the left outer proximal gluteal area. The area measured 2.0 cm x 2.0 cm. Another Skin</p>		<p>constitute an agreement or admission of the survey allegations.</p> <p>F282 -483.20 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B no resides in the community. Residents H and I have had a complete skin assessment performed and are receiving appropriate treatment, weekly skin assessments, and preventative care. There is evidence on the weekly skin assessment that the wound is healing. Care plans have been reviewed and updated to reflect current plan of care and current resident status. The nurse practitioner for resident H and I has been on site since this survey and has reviewed the plans of care and evaluated the wounds. Physician orders and care plan interventions are being followed on residents who have acquired pressure ulcers.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>All residents who have pressure ulcers have the potential to be effected. Residents who have pressure ulcers have the potential to be effected. Residents who have pressures ulcers have been identified. Care plans for residents</p>	

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	<p>Condition Assessment dated 6/2/16, indicated a left outer distal gluteal area listed as "shearing." The wound measured 1.0 cm x 0.5 cm. The date of origin was 5/31/16.</p> <p>On 6/9/16, a Skin Condition Assessment indicated a "shearing" on the outer gluteal area. The area measured 1.0 cm x 0.5 cm and was a stage 2 pressure area.</p> <p>A Skin Condition Assessment on 6/16/16, indicated a "shearing" on the left. No other mention of the area was noted. The area measured 1.5 cm x 1.0 cm. No staging was noted.</p> <p>On 6/22/16, a Skin Condition Assessment indicated a left gluteal fold area. The area measured 2.8 cm x 0.6 cm x 0.2 cm. The area was now listed as a stage 3 pressure ulcer. (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed).</p> <p>On 6/30/16, a Skin Condition Assessment indicated a "pressure sore" on the left gluteal fold. The area measured 1.9 cm x 0.9 cm x 0.1 cm. The area was listed as a stage 3 pressure area.</p> <p>The Skin Condition Assessment dated 7/6/16, indicated a "pressure sore" on the</p>		<p>identified as high-risk for developing skin breakdown have been reviewed to ensure appropriate interventions and treatment orders are in place.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Nurse Managers have been re-educated on obtaining and ensuring treatment orders are appropriate and in place for all residents with pressure ulcers as well as care plan interventions. DON or designee will review all treatment orders and care plans of residents with pressure ulcers weekly during IDT. Nursing staff will be in-serviced by Staff Development Coordinator on obtaining immediate and appropriate treatment orders and updating care plans to reflect current plan of care. Acquired pressure ulcers will be discussed during the weekly interdisciplinary meeting for appropriate interventions, care planning, and implementation of preventative care.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will review</p>	

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	<p>left gluteal fold that measured 1.5 cm x 2.2 cm x 0.2 cm. No stage was noted.</p> <p>The Skin Condition Assessment dated 7/15/16, indicated the same area measured 2.7 cm x 1.1 cm x 0.2 cm. The pressure area was a stage 3 wound.</p> <p>The Skin Condition Assessment dated 7/21/16, indicated the same area measured 1.8 cm x 0.5 cm x 0.2 cm. The pressure area was a stage 3 wound.</p> <p>Review of a Physician's Order dated 3/30/16, indicated the following: ...Order Description: Apply border foam dressing to wound of L [left] buttock Frequency: Once A Morning Every 3 Days... Special Instructions: Clean wound with normal saline, apply scant amount of silva collagen [antimicrobial gel] and apply border foam daily. PRN as needed d/t [due to] soilage. The order was received by LPN #1.</p> <p>During an interview on 7/22/16 at 3:35 p.m., the Director of Nursing (DON) indicated the order for Resident I was not correct. She indicated the order should have been done daily, not every 3 days as listed.</p> <p>Review of the Treatment Administration</p>		<p>treatment orders and care plan interventions of acquired pressure ulcers weekly for 4 weeks, then monthly for 2 months, then quarterly thereafter for a total of 12 months. Any identified concerns from the audit will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance date: 08/01/2016. The Administrator at Countryside Manor Health and Living Community is responsible in ensuring compliance in this Plan of Correction</p>				

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	<p>History from 3/30/16 through 6/20/16, the treatment was done every 3 days.</p> <p>On 6/22/16, an order was received from the Nurse Practitioner to have Resident I evaluated and treated by the wound nurse. The order was received after the wound increased from a stage 2 to a stage 3 wound.</p> <p>Review of a current care plan dated 6/2/16, indicated Resident I had a problem with an open area to the left outer proximal and distal gluteal area. Interventions included, but were not limited to, administer medications as prescribed by MD [medical doctor] and administer treatments as prescribed by MD. The care plan indicated on 6/9/16, the left outer proximal and distal gluteal now formed one area.</p> <p>Wound care and dressing change was observed on 7/25/16 at 11:25 a.m. by LPN #2.</p> <p>During an interview on 7/25/16 at 3:23 p.m. with the DON, LPN #1 and Corporate Nurse, the DON indicated the wound was not initially classified as a pressure area. LPN #1 indicated Resident I had two areas, one on the left gluteal and one on the coccyx that combined into one pressure area. She indicated the</p>			

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	<p>nurses do a weekly skin assessment and if there are any skin concerns, she follows up with them weekly as unit manager.</p> <p>2. The closed clinical record of Resident B was reviewed on 7/21/16 at 11:20 a.m. Diagnoses for the resident included, but were not limited to, hypertension, heart failure cerebral infarct with right side weakness, dyspnea, pressure ulcer stage 2, hypertension and sepsis. Resident B was admitted to the facility on 5/10/16.</p> <p>A review of Resident B's MDS 60-day review dated 7/6/16, indicated the resident was severely cognitively impaired and required extensive assistance and two plus person physical assistance with bed mobility and transfers.</p> <p>Review of a Skin Condition Assessment dated 5/18/16, Resident B was noted to have a pressure wound to the coccyx area. The area measured 2.0 cm x 1.0 cm x 0.1 cm. The area was listed as a stage 2 wound. The area was not present on admission.</p> <p>An order was received on 5/17/16 to start DermaSeptine (barrier cream) around the wound area the apply Mepilex (foam dressing) over open area. The dressing was to be changed daily for 7 days then</p>			

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	<p>re-evaluated. The treatment was done 5/18/16 through 5/24/16.</p> <p>Review of a Skin Condition Assessment dated 5/26/16, indicated a pressure area to the coccyx that measured 1.0 cm x 1.0 cm. No staging was listed.</p> <p>Review of a Skin Condition Assessment dated 6/1/16, indicated a pressure area to the coccyx that measured 3.5 cm x 3.5 cm x 0.1 cm. The wound was noted as a stage 2 wound.</p> <p>Review of the Treatment Administration History from 5/25/16 through 6/4/16, Resident B did not receive any treatment for the pressure wound for 10 days.</p> <p>A Physician's Order dated 6/4/16, indicated to apply DermaSeptine to the right gluteal area and cover with Mepilex twice daily. The order was discontinued on 6/7/16. A new order was received on 6/6/16 to place Xerofoam (petrolatum dressing gauze) to the right gluteal area and cover with Mepilex daily. The treatment was done 6/6/16 through 6/22/16.</p> <p>Review of a Skin Condition Assessment dated 6/8/16, indicated a pressure area to the coccyx that measured 4.0 cm x 3.0 cm x 0.1. The wound was noted as a</p>			

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	<p>stage 2 wound.</p> <p>On 6/15/16, a Skin Condition Assessment indicated the coccyx wound measured 3.75 cm x 2.25 cm x 0.1 cm. The wound was noted as a stage 2 wound.</p> <p>On 6/15/16, Physician's Order indicated for Resident B to have a wound consult.</p> <p>On 6/22/16, a Skin Condition Assessment indicated the coccyx wound measured 4.0 cm x 3.2 cm x 0.1 cm. No wound stage was noted.</p> <p>A Wound Nurse Progress Note dated 6/22/16, indicated a right coccyx, stage 3 pressure wound that measured 3.0 cm x 4.0 cm x 0.1 cm. An order to clean the wound with saline, apply SilvaKollagen to wound bed and cover with border foam dressing daily was received.</p> <p>Resident B was seen on 6/29/16 by the wound nurse. The wound measured 3.0 cm x 2.0 cm x 0.1 cm. No new order was received.</p> <p>A Skin Condition Assessment dated 6/30/16, indicated the pressure area to the coccyx measured 3.0 cm x 2.0 cm x 0.1. The wound was noted as a stage 3 wound.</p>			

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	<p>A Skin Condition Assessment dated 7/7/16, indicated the pressure area to the coccyx measured 3.2 cm x 1.4 cm x 0.1. The wound was noted as a stage 3 wound.</p> <p>Resident B was seen on 7/6/16 by the wound nurse. The wound measured 3.2 cm x 1.4 cm x 0.1 cm. No new order was received.</p> <p>Review of a current care plan dated 5/18/16, indicated the following: "Resident has a pressure ulcer R/T [related to] res [resident] chooses not to turn and reposition...." Interventions included, but were not limited to, turn as reposition as resident allows and conduct a systematic skin inspection every shift and report any signs of further skin breakdown.</p> <p>During an interview on 7/22/16 at 1:56 p.m., the DON indicated she could not find any re-evaluation from the order dated 5/17/16. The DON also indicated she could not find any documentation of a refusal to turn and reposition from 5/1/16 through 5/31/16 for Resident B.</p> <p>During an interview on 7/25/16 at 10:43 a.m., LPN #4 indicated the gluteal wound and the coccyx wound were the same</p>			

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	<p>wound. She indicated there was no contact with the physician related to the follow-up care for the wound. She indicated "clearly an order to re-eval should not happen again." She indicated staff were still using the DermaSeptine, but were not documenting it. She indicated she was not sure why Resident B had a care plan stating refusal to turn and reposition dated the same day as the wound was noted.</p> <p>3. The clinical record of Resident H was reviewed on 7/22/16 at 11:03 a.m. Diagnoses for the resident included, but were not limited to, hypertension, dysphagia, hemiplegia and cellulitis of left leg.</p> <p>Review of Resident H's Quarterly MDS dated 5/6/16, indicated the resident was cognitively intact and required extensive assistance and two plus person physical assistance with bed mobility.</p> <p>Review of an Event Report dated 7/1/16, Resident H was noted to have an open area to the right ankle. The area measured 1.0 cm x 1.0 cm. The area was not present on admission. The physician was notified on 7/1/16 and a new order for Bactroban (antibacterial ointment) was received. The medication was to be applied to the right ankle for 10 days.</p>			

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	<p>The ointment was applied from 7/1/16 through 7/11/16.</p> <p>A Skin Condition Assessment dated 7/1/16, indicated a right ankle pressure wound that measured 1.0 cm x 1.0 cm. The wound was listed a a stage 2.</p> <p>A Skin Condition Assessment dated 7/6/16, indicated the wound measured 1.0 cm x 0.5 cm.</p> <p>A Skin Condition Assessment dated 7/15/16, indicated the wound measured 0.8 cm x 0.8 cm.</p> <p>On 7/21/16, a Skin Condition Assessment indicated an abrasion that measured 0.5 cm x 0.5 cm x 0.1 cm. The wound was listed as unstageable.</p> <p>Review of Progress Notes from 7/1/16 through 7/25/16, indicated the following: "7/13/16 at 9:44 p.m.-...o/a [open area] to ankle.... 7/14/16 at 10:00 p.m.-...denies pain to oa to ankle.... 7/15/16 at 12:40 p.m.-Treatment continues to open area.... 7/16/16 at 10:43 p.m.-Treatment continues to open area... 7/17/16 at 11:20 a.m.-Treatment continues to open area... 7/17/16 at 10:37 p.m.-No longer</p>			

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	<p>receiving treatment to OA...."</p> <p>A Physician's Order dated 7/21/16, indicated Betadine 10% topical, paint to right ankle and let dry. Cover with hydrocolloid dressing and change on Monday, Wednesday and Friday.</p> <p>Review of the Treatment Administration History from 7/1/16 through 7/25/16, Resident H received Bactroban from 7/1/16 through 7/11/16 and Betadine from 7/21/16 through 7/25/16. No treatment was obtained for the documented open area from 7/12/16 through 7/19/16.</p> <p>Review of a current care plan dated 7/1/16, indicated Resident H had pressure area to the right ankle. Interventions included, but were not limited to, conduct a systematic skin inspection every shift and report any signs of further skin breakdown.</p> <p>Wound care and dressing change was observed on 7/25/16 at 11:05 a.m. by LPN #2.</p> <p>Review of a current facility policy dated 1/15/15, titled "Skin risk policy", which was provided by the DON on 7/22/16 at 2:00 p.m., indicated the following:</p>			

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F 0314 SS=G Bldg. 00	<p>"Policy Statement Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).</p> <p>1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician....</p> <p>...e. A need to alter the resident's medical treatment significantly;....</p> <p>2. A "significant change" of condition is a decline or improvement in the resident's status that:</p> <p>a. Will not normally resolve itself without intervention...</p> <p>...c. Requires interdisciplinary review and/or revision to the care plan...."</p> <p>This Federal tag relates to Complaints IN00204669 and IN00205639.</p> <p>3.1-35(g)(2)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of</p>						

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	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to prevent the development of a pressure ulcer resulting in a stage 3 wound for 2 of 5 residents reviewed for pressure wounds (Residents B and I). The facility also failed to ensure a resident received continued treatment for a pressure wound for 1 of 5 residents reviewed. (Resident H)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record of Resident I was reviewed on 7/22/16 at 10:20 a.m. Diagnoses for the resident included, but were not limited to, Parkinson's disease, diabetes mellitus, pressure ulcer of right buttock-stage 2, hypertension, kidney failure and dysphagia. <p>A review of Resident I's Minimum Data Set (MDS) Quarterly Review dated 5/12/16, indicated the resident was severely cognitively impaired and required extensive assistance and two</p>	F 0314	<p>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> <p>F314 -483.25 TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident B no longer resides in the community. Resident H and I has had a complete skin assessment performed and is receiving appropriate treatment, weekly skin assessments, and preventative care. There is evidence on the weekly skin assessment that the wounds are</p>	08/02/2016

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	<p>plus person physical assistance with bed mobility and transfers.</p> <p>Review of a Skin Condition Assessment dated 3/31/16, Resident I was noted to have an abrasion to the right outer gluteal area. The area measured 1.8 cm x 0.5 cm. The area was obtained in the facility. The area was noted as healed on 4/8/16.</p> <p>Review of an Event Report for Resident I dated 6/1/16, an open area to the left gluteal area was noted. The Nurse Practitioner was notified and gave new orders for Santyl (wound ointment) 250 unit/gram nickel sized amount to the wound and then cover with Mepilex (foam dressing), change daily and as needed.</p> <p>On 6/2/16, a Skin Condition Assessment indicated a "shearing" on the left outer proximal gluteal area. The area measured 2.0 cm x 2.0 cm. Another Skin Condition Assessment dated 6/2/16, indicated a left outer distal gluteal area listed as "shearing." The wound measured 1.0 cm x 0.5 cm. The date of origin was 5/31/16.</p> <p>On 6/9/16, a Skin Condition Assessment indicated a "shearing" on the outer gluteal area. The area measured 1.0 cm x 0.5 cm and was a stage 2 pressure area.</p>		<p>healing. The wound care Nurse Practitioner has seen residents H and I in the facility and has assessed wounds to both residents with progress notes written.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</p> <p>Residents who are at risk for pressure ulcers could be affected. Residents who are at risk for pressure ulcers have been identified. Care plans for residents identified as high-risk for developing skin breakdown have been reviewed to ensure appropriate interventions are in place.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?</p> <p>Nurse Managers have been re-educated on continued appropriate treatment orders for residents with acquired pressure ulcers. Pressure reduction interventions will be documented on the resident TAR. DON or designee will review appropriate treatment orders are in place on acquired pressure ulcers during the weekly IDT. Nursing staff will be in-serviced by Staff Development Coordinator on risk factors for skin breakdown and interventions to prevent pressure wound development. New acquired pressure ulcers will be</p>	

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	<p>A Skin Condition Assessment on 6/16/16, indicated a "shearing" on the left. No other mention of the area was noted. The area measured 1.5 cm x 1.0 cm. No staging was noted.</p> <p>On 6/22/16, a Skin Condition Assessment indicated a left gluteal fold area. The area measured 2.8 cm x 0.6 cm x 0.2 cm. The area was now listed as a stage 3 pressure ulcer. (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed).</p> <p>On 6/30/16, a Skin Condition Assessment indicated a "pressure sore" on the left gluteal fold. The area measured 1.9 cm x 0.9 cm x 0.1 cm. The area was listed as a stage 3 pressure area.</p> <p>The Skin Condition Assessment dated 7/6/16, indicated a "pressure sore" on the left gluteal fold that measured 1.5 cm x 2.2 cm x 0.2 cm. No stage was noted.</p> <p>The Skin Condition Assessment dated 7/15/16, indicated the same area measured 2.7 cm x 1.1 cm x 0.2 cm. The pressure area was a stage 3 wound.</p> <p>The Skin Condition Assessment dated 7/21/16, indicated the same area</p>		<p>discussed during the weekly interdisciplinary meeting for appropriate interventions, care planning and implementation of preventative care.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON or designee will review treatment orders and care plan interventions of acquired pressure ulcers weekly for 4 weeks, then monthly for 2 months, then quarterly thereafter for a total of 12 months. Any identified concerns from the audit will be addressed immediately. Results of the reviews will be presented at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed.</p> <p>Compliance date: 08/01/2016. The Administrator at Countryside Manor Health and Living Community is responsible in ensuring compliance in this Plan of Correction.</p>	

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	<p>measured 1.8 cm x 0.5 cm x 0.2 cm. The pressure area was a stage 3 wound.</p> <p>Review of a Physician's Order dated 3/30/16, indicated the following: ...Order Description: Apply border foam dressing to wound of L [left] buttock Frequency: Once A Morning Every 3 Days... Special Instructions: Clean wound with normal saline, apply scant amount of silva kollagen [antimicrobial gel] and apply border foam daily. PRN as needed d/t [due to] soilage. The order was received by LPN #1.</p> <p>During an interview on 7/22/16 at 3:35 p.m., the Director of Nursing (DON) indicated the order for Resident I was not correct. She indicated the order should have been done daily, not every 3 days as listed.</p> <p>Review of the Treatment Administration History from 3/30/16 through 6/20/16, the treatment was done every 3 days.</p> <p>On 6/22/16, an order was received from the Nurse Practitioner to have Resident I evaluated and treated by the wound nurse. The order was received after the wound increased from a stage 2 to a stage 3 wound.</p>			

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	<p>Review of a current care plan dated 6/2/16, indicated Resident I had a problem with an open area to the left outer proximal and distal gluteal area. Interventions included, but were not limited to, administer medications as prescribed by MD [medical doctor] and administer treatments as prescribed by MD. The care plan indicated on 6/9/16, the left outer proximal and distal gluteal now formed one area.</p> <p>Wound care and dressing change was observed on 7/25/16 at 11:25 a.m. by LPN #2.</p> <p>During an interview on 7/25/16 at 3:23 p.m. with the DON, LPN #1 and Corporate Nurse, the DON indicated the wound was not initially classified as a pressure area. LPN #1 indicated Resident I had two areas, one on the left gluteal and one on the coccyx that combined into one pressure area. She indicated the nurses do a weekly skin assessment and if there are any skin concerns, she follows up with them weekly as unit manager.</p> <p>2. The closed clinical record of Resident B was reviewed on 7/21/16 at 11:20 a.m. Diagnoses for the resident included, but were not limited to, hypertension, heart failure cerebral infarct with right side weakness, dyspnea, pressure ulcer stage</p>			

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	<p>2, hypertension and sepsis. Resident B was admitted to the facility on 5/10/16.</p> <p>A review of Resident B's MDS 60-day review dated 7/6/16, indicated the resident was severely cognitively impaired and required extensive assistance and two plus person physical assistance with bed mobility and transfers.</p> <p>Review of a Skin Condition Assessment dated 5/18/16, Resident B was noted to have a pressure wound to the coccyx area. The area measured 2.0 cm x 1.0 cm x 0.1 cm. The area was listed as a stage 2 wound. The area was not present on admission.</p> <p>An order was received on 5/17/16 to start DermaSeptine (barrier cream) around the wound area the apply Mepilex (foam dressing) over open area. The dressing was to be changed daily for 7 days then re-evaluated. The treatment was done 5/18/16 through 5/24/16.</p> <p>Review of a Skin Condition Assessment dated 5/26/16, indicated a pressure area to the coccyx that measured 1.0 cm x 1.0 cm. No staging was listed.</p> <p>Review of a Skin Condition Assessment dated 6/1/16, indicated a pressure area to</p>			

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	<p>the coccyx that measured 3.5 cm x 3.5 cm x 0.1 cm. The wound was noted as a stage 2 wound.</p> <p>Review of the Treatment Administration History from 5/25/16 through 6/4/16, Resident B did not receive any treatment for the pressure wound for 10 days.</p> <p>A Physician's Order dated 6/4/16, indicated to apply DermaSeptine to the right gluteal area and cover with Mepilex twice daily. The order was discontinued on 6/7/16. A new order was received on 6/6/16 to place Xerofoam (petrolatum dressing gauze) to the right gluteal area and cover with Mepilex daily. The treatment was done 6/6/16 through 6/22/16.</p> <p>Review of a Skin Condition Assessment dated 6/8/16, indicated a pressure area to the coccyx that measured 4.0 cm x 3.0 cm x 0.1. The wound was noted as a stage 2 wound.</p> <p>On 6/15/16, a Skin Condition Assessment indicated the coccyx wound measured 3.75 cm x 2.25 cm x 0.1 cm. The wound was noted as a stage 2 wound.</p> <p>On 6/15/16, Physician's Order indicated for Resident B to have a wound consult.</p>			

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	<p>On 6/22/16, a Skin Condition Assessment indicated the coccyx wound measured 4.0 cm x 3.2 cm x 0.1 cm. No wound stage was noted.</p> <p>A Wound Nurse Progress Note dated 6/22/16, indicated a right coccyx, stage 3 pressure wound that measured 3.0 cm x 4.0 cm x 0.1 cm. An order to clean the wound with saline, apply SilvaKollagen to wound bed and cover with border foam dressing daily was received.</p> <p>Resident B was seen on 6/29/16 by the wound nurse. The wound measured 3.0 cm x 2.0 cm x 0.1 cm. No new order was received.</p> <p>A Skin Condition Assessment dated 6/30/16, indicated the pressure area to the coccyx measured 3.0 cm x 2.0 cm x 0.1. The wound was noted as a stage 3 wound.</p> <p>A Skin Condition Assessment dated 7/7/16, indicated the pressure area to the coccyx measured 3.2 cm x 1.4 cm x 0.1. The wound was noted as a stage 3 wound.</p> <p>Resident B was seen on 7/6/16 by the wound nurse. The wound measured 3.2 cm x 1.4 cm x 0.1 cm. No new order was</p>			

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	<p>received.</p> <p>Review of a current care plan dated 5/18/16, indicated the following: "Resident has a pressure ulcer R/T [related to] res [resident] chooses not to turn and reposition...." Interventions included, but were not limited to, turn as reposition as resident allows.</p> <p>During an interview on 7/22/16 at 1:56 p.m., the DON indicated she could not find any re-evaluation from the order dated 5/17/16. The DON also indicated she could not find any documentation of a refusal to turn and reposition from 5/1/16 through 5/31/16 for Resident B.</p> <p>During an interview on 7/25/16 at 10:43 a.m., LPN #4 indicated the gluteal wound and the coccyx wound were the same wound. She indicated there was no contact with the physician related to the follow-up care for the wound. She indicated "clearly an order to re-eval should not happen again." She indicated staff were still using the DermaSeptine, but were not documenting it. She indicated she was not sure why Resident B had a care plan stating refusal to turn and reposition dated the same day as the wound was noted.</p> <p>3. The clinical record of Resident H was</p>			

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	<p>reviewed on 7/22/16 at 11:03 a.m. Diagnoses for the resident included, but were not limited to, hypertension, dysphagia, hemiplegia and cellulitis of left leg.</p> <p>Review of Resident H's Quarterly MDS dated 5/6/16, indicated the resident was cognitively intact and required extensive assistance and two plus person physical assistance with bed mobility.</p> <p>Review of an Event Report dated 7/1/16, Resident H was noted to have an open area to the right ankle. The area measured 1.0 cm x 1.0 cm. The area was not present on admission. The physician was notified on 7/1/16 and a new order for Bactroban (antibacterial ointment) was received. The medication was to be applied to the right ankle for 10 days. The ointment was applied from 7/1/16 through 7/11/16.</p> <p>A Skin Condition Assessment dated 7/1/16, indicated a right ankle pressure wound that measured 1.0 cm x 1.0 cm. The wound was listed a a stage 2.</p> <p>A Skin Condition Assessment dated 7/6/16, indicated the wound measured 1.0 cm x 0.5 cm.</p> <p>A Skin Condition Assessment dated</p>			

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	<p>7/15/16, indicated the wound measured 0.8 cm x 0.8 cm.</p> <p>On 7/21/16, a Skin Condition Assessment indicated an abrasion that measured 0.5 cm x 0.5 cm x 0.1 cm. The wound was listed as unstageable.</p> <p>Review of Progress Notes from 7/1/16 through 7/25/16, indicated the following: "7/13/16 at 9:44 p.m.-...o/a [open area] to ankle.... 7/14/16 at 10:00 p.m.-...denies pain to oa to ankle.... 7/15/16 at 12:40 p.m.-Treatment continues to open area.... 7/16/16 at 10:43 p.m.-Treatment continues to open area... 7/17/16 at 11:20 a.m.-Treatment continues to open area... 7/17/16 at 10:37 p.m.-No longer receiving treatment to OA...."</p> <p>A Physician's Order dated 7/21/16, indicated Betadine 10% topical, paint to right ankle and let dry. Cover with hydrocolloid dressing and change on Monday, Wednesday and Friday.</p> <p>Review of the Treatment Administration History from 7/1/16 through 7/25/16, Resident H received Bactroban from 7/1/16 through 7/11/16 and Betadine from 7/21/16 through 7/25/16. No</p>			

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	<p>treatment was obtained for the documented open area from 7/12/16 through 7/19/16.</p> <p>Review of a current care plan dated 7/1/16, indicated Resident H had pressure area to the right ankle. Interventions included, but were not limited to, conduct a systematic skin inspection every shift and report any signs of further skin breakdown.</p> <p>Wound care and dressing change was observed on 7/25/16 at 11:05 a.m. by LPN #2.</p> <p>Review of a current facility policy dated 1/15/15, titled "Skin risk policy", which was provided by the DON on 7/22/16 at 3:54 p.m., indicated the following:</p> <p>"Policy Statement Policy: Residents within a CarDon community will have a head-to-toe skin assessment completed by a licensed nurse upon admission and weekly thereafter. The head-to-toe skin assessment will be charted as completed by the licensed nurse. The nurse doing the assessment will document any abnormal findings affecting the skin.</p> <p>...The licensed nurse that discovers a new open area will perform the following</p>			

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	<p>actions:</p> <ol style="list-style-type: none"> 1. Notify the MD and obtain a treatment order 2. Apply the initial treatment 3. Notify the immediate nursing supervisor 4. Notify the family 5. Inform the other caregivers to ensure preventative actions are put into place to promote healing. 6. Document these items in the patient medical record." <p>This Federal tag relates to Complaints IN00204669 and IN00205639.</p> <p>3.1-40(a)(1)(2)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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 07/25/2016
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	