

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2014
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00154620 and IN00155458.</p> <p>Complaint IN00154620 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F225, and F226.</p> <p>Complaint IN00155458 - Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F325, and F364.</p> <p>Survey Dates: September 30, and October 1, 2, 3, 6, & 7, 2014.</p> <p>Facility Number: 012534 Provider Number: 155792 AIM Number: 201028420</p> <p>Survey Team: Kewanna Gordon RN-TC Lora Brettnacher RN Tracina Moody RN (October 2,3,6, & 7, 2014)</p> <p>Census bed type: SNF: 12 SNF/NF: 129 Total: 141</p>	F000000	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. The provider respectfully request that the 2567 Plan of Correction be considered the letter of credible allegation and request a post certification desk review in lieu of post survey re-visit on or after October 31, 2014	

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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F000157 SS=D	<p>Census payor type: Medicare: 16 Medicaid: 94 Other: 17 Total: 141</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 10/10/14 by Brenda Marshall, RN.</p> <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</p>			
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	<p>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 notify a physician when a resident had a significant change in condition for 1 of 3 residents reviewed for physician notification (Resident H).</p> <p>Findings include:</p> <p>Resident H's record was reviewed on 10/06/14 at 9:14 am. Resident H had diagnoses which included but were not limited to, edema, kidney failure, and chronic systolic heart failure.</p> <p>A physician's order, dated 5/9/14 at 3:00 p.m., indicated orders for staff to obtain Resident H's weights daily and to notify the physician of a two pound weight gain in one day or of a five pound weight gain in one week.</p> <p>Medication Administration Records</p>	F000157	<p>F157-</p> <p>·what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>Resident H was not identified</p> <p>·how otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken;</p> <p>All Residents with orders for dailyweights have the potential to be affected. All Residents with daily weight orderswere reviewed by DNS for appropriate documentation of weights and notification. DNS/designee will in-service LicensedNursing Staff on or before Oct 28th on MD notification of weightchanges.</p>	10/31/2014			

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	<p>(MAR) were reviewed for May 2014 and June 2014. The May 2014, MAR indicated Resident H's weight on May 31, 2014, was 205.1 pounds. The June 2014, Mar indicated Resident H's weight on June 1, 2014 was 214.8 pounds. The record lacked documentation which indicated the physician was notified of the 9.7 pound weight gain.</p> <p>During an interview on 10/7/14 at 1:15 p.m., the Director of Nursing (DON) indicated the record lacked documentation which indicated the weight was an error or the physician had been notified of the 9.7 pound weight gain. She indicated the physician should have been notified of the 9.7 pound weight gain.</p> <p>A policy titled "Change of Condition" identified as current by the DON on 10/7/14, indicated, "...It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention occurs... All symptoms and unusual signs will be documented in the medical record and communicated to the attending physician promptly..."</p> <p>This Federal tag relates to Complaints IN00154620 and IN00155458.</p>		<p>-what measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>DNS/designee will in-service Licensed Nursing Staff on or before Oct 28th on MD notification of weight changes. Unit Managers will audit weights on daily weight notification form to ensure weights are obtained/documented and proper notification is carried out. Staff not in compliance with plan will receive further education and/or disciplinary action.</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;</p> <p>Daily weight monitoring CQI tool will be completed weekly x 4 weeks, monthly x 6, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>	

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F000225 SS=D	<p>3.1-5(a)(2)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of</p>						

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	<p>the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 allegations of abuse reviewed. (Resident H).</p> <p>Findings include:</p> <p>Resident H's record was reviewed on 10/06/14 at 9:14 am. A quarterly Minimum Data Set assessment tool (MDS) completed on 4/18/14, indicated Resident H had a Brief Interview Mental Status score of 6 out of 15 and was dependent on staff for mobility.</p> <p>A nurse's note, dated 6/15/14 at 11:13 p.m., indicated, "CNA [Certified Nursing Assistant] informed writer that resident co [sic] [complained] eye pain and noticed swelling around the eye. Upon interviewing resident, writer was informed resident may have been hit in the eye by resident's roommate. Residents were immediately separated and the ed [Executive Director] physician and family were notified. Neuros [neurological assessments] and vs [vitals] are wnl [within normal limits] ice applied for swelling..."</p>	F000225	<p>-what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>ResidentH was not identified</p> <p>-how otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken;</p> <p>All Residents have the potential to beaffected. All other current allegationswere reviewed by Ed/Designee to ensure investigation completed and properdocumentation is in place. SS/Nursingconsultant reviewed abuse policy/procedure with ED/DNS. ED/DNS will investigate all instances ofalleged abuse according to policy.</p> <p>-what measureswill be put in to place or what systemic changes will be made to ensure thatthe deficient practice does not recur;</p> <p>SS/Nursing consultant reviewed abusepolicy/procedure with ED/DNS. ED/DNSwill investigate all instances of alleged abuse</p>	10/31/2014

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	<p>During an interview on 10/07/2014 at 12:26 p.m., the Director of Nursing (DON) indicated she received a call from the night shift nurse who indicated Resident H had informed her of an allegation of abuse. The DON indicated the alleged perpetrator was alert, oriented, and ambulatory. She indicated the Executive Director immediately came in and interviewed both residents. She indicated Resident H did not verbally report to them his roommate had hit him. She indicated he "lifted his fist" in a punching manner. The alleged perpetrator denied hitting Resident H but indicated he was "just helping him up in bed." She indicated the residents were separated, the police was called, the incident was reported to the State, and the alleged perpetrator was put on one on one supervision until discharged the next day. The DON indicated because Resident H had full body edema and they were unable to verify if he was "punched" by his room mate further investigation was not completed. She indicated residents other than the two residents involved and staff other than CNA #8 and LPN #10 was not interviewed.</p> <p>During a telephone interview on 10/7/14 at 3:38 p.m., Certified Nursing Assistant #8 stated, "I went inside the room and</p>		<p>according to policy. Each allegation of abuse will be thoroughly investigated per policy by ED/Designee to ensure Residents are protected from further potential abuse. Each allegation will include statements from Residents and staff. ED/Designee will review statements from all involved to ensure appropriate action is taken.</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;</p> <p>Abuse Prohibition and Investigation CQI tool will be completed weekly x 4 weeks, monthly x 6, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>				

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	<p>noticed his eye was swollen. He was pointing at his eye. I said, 'Oh my goodness, what happened.' He pointed at the roommate and whispered, 'He hit me.' I asked him why and he shrugged his shoulders. I had to write out a statement. I put it under the ed's [Executive Director] door... He was shaking and all drawn up and his non verbal body language told me he was fearful..."</p> <p>During a telephone interview on 10/7/14 at 4:21 p.m., Licensed Practical Nurse #10 stated, "A CNA (Certified Nursing Assistant) came and got me. [Resident H named] said he had been assaulted. He was concerned about his eye. He kept pointing at it... His eye was puffy. He did have puffy eyes before but the one eye was a little more puffy... It wasn't like him to be that agitated against his room mate. He kept pointing over there. He could speak a little bit... His room mate did not like [Resident H named]. He kept telling me to get him out of the room. [Resident H named] is one who tried to get up all the time and his bed alarm would be going off and [alleged perpetrator named] just wanted everything quiet and to himself. It agitated [alleged perpetrator named].</p> <p>A policy titled "Abuse Prohibition, Reporting, and Investigation" identified</p>			

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F000226 SS=D	<p>as current by the DON on 10/7/14 at 4:14 p.m., indicated, "...American Senior Communities will not permit residents to be subjected to abuse by anyone...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed...A comprehensive record of the abuse investigation is to be kept by the facility Executive Director and/or Director of Nursing.</p> <p>This Federal tag relates to Complaint IN00154620.</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to implement its policies and procedures to thoroughly investigate an allegation of abuse for 1 of 3 allegations of abuse reviewed. (Resident H).</p> <p>Findings include:</p>	F000226	<p>-what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>ResidentH was not identified</p> <p>-how otherresidents having the potential to be affected by the same deficient practicewill</p>	10/31/2014

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	<p>Resident H's record was reviewed on 10/06/14 at 9:14 am. A quarterly Minimum Data Set assessment tool (MDS) completed on 4/18/14, indicated Resident H had a Brief Interview Mental Status score of 6 out of 15 and was dependent on staff for mobility.</p> <p>A nurse's note, dated 6/15/14 at 11:13 p.m., indicated, "CNA [Certified Nursing Assistant] informed writer that resident co [sic] [complained] eye pain and noticed swelling around the eye. Upon interviewing resident, writer was informed resident may have been hit in the eye by resident's roommate. Residents were immediately separated and the ed [Executive Director] physician and family were notified. Neuros [neurological assessments] and vs [vitals] are wnl [within normal limits] ice applied for swelling..."</p> <p>During an interview on 10/07/2014 at 12:26 p.m., the Director of Nursing (DON) indicated she received a call from the night shift nurse who indicated Resident H had informed her of an allegation of abuse. The DON indicated the alleged perpetrator was alert, oriented, and ambulatory. She indicated the Executive Director immediately came in and interviewed both residents. She</p>		<p>be identified and what corrective action(s) will be taken;</p> <p>All Residents have the potential to be affected. All other allegations were reviewed by ED/Designee to ensure investigation completed and proper documentation is in place. SS/Nursing consultant reviewed abuse policy/procedure with ED/DNS. ED/DNS will investigate all instances of alleged abuse according to policy.</p> <p>-what measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>SS/Nursing consultant reviewed abuse policy/procedure with ED/DNS. ED/DNS will investigate all instances of alleged abuse according to policy. Each allegation of abuse will be thoroughly investigated per policy by ED/Designee to ensure Residents are protected from further potential abuse. Each allegation will include statements from Residents and staff. ED/Designee will review statements from all involved to ensure appropriate action is taken.</p> <p>-how the corrective action(s) will be monitored to ensure the</p>				

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	<p>indicated Resident H did not verbally report to them his roommate had hit him. She indicated he "lifted his fist" in a punching manner. The alleged perpetrator denied hitting Resident H but indicated he was "just helping him up in bed." She indicated the residents were separated, the police was called, the incident was reported to the State, and the alleged perpetrator was put on one on one supervision until discharged the next day. The DON indicated because Resident H had full body edema and they were unable to verify if he was "punched" by his room mate further investigation was not completed. She indicated residents other than the two residents involved and staff other than CNA #8 and LPN #10 was not interviewed.</p> <p>During a telephone interview on 10/7/14 at 3:38 p.m., Certified Nursing Assistant #8 stated, "I went inside the room and noticed his eye was swollen. He was pointing at his eye. I said, 'Oh my goodness, what happened.' He pointed at the roommate and whispered, 'He hit me.' I asked him why and he shrugged his shoulders. I had to write out a statement. I put it under the ed's [Executive Director] door... He was shaking and all drawn up and his non verbal body language told me he was fearful..."</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>Abuse Prohibition and Investigation CQI tool will be completed weekly x 4 weeks, monthly x6, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>	

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	<p>During a telephone interview on 10/7/14 at 4:21 p.m., Licensed Practical Nurse #10 stated, "A CNA (Certified Nursing Assistant) came and got me. [Resident H named] said he had been assaulted. He was concerned about his eye. He kept pointing at it... His eye was puffy. He did have puffy eyes before but the one eye was a little more puffy... It wasn't like him to be that agitated against his room mate. He kept pointing over there. He could speak a little bit... His room mate did not like [Resident H named]. He kept telling me to get him out of the room. [Resident H named] is one who tried to get up all the time and his bed alarm would be going off and [alleged perpetrator named] just wanted everything quiet and to himself. It agitated [alleged perpetrator named].</p> <p>A policy titled "Abuse Prohibition, Reporting, and Investigation" identified as current by the DON on 10/7/14 at 4:14 p.m., indicated, "...American Senior Communities will not permit residents to be subjected to abuse by anyone...The Executive Director is the designated individual responsible for coordinating all efforts in the investigation of abuse allegations, and for assuring that all policies and procedures are followed...A comprehensive record of the abuse investigation is to be kept by the facility</p>			

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F000242 SS=E	<p>Executive Director and/or Director of Nursing.</p> <p>This Federal tag relates to Complaints IN00154620.</p> <p>3.1-28(a)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were given choices regarding their preference for frequency of showers and wake up times for 2 of 3 sampled residents. (Residents #15 and #6).</p> <p>Findings include:</p> <p>A review of Resident # 15's chart, on 10/7/14 at 10:21 a.m., indicated he had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the facility had evaluated him to be cognitively intact.</p> <p>During an interview on, 10/3/14 at 9:48</p>	F000242	<p>·what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>Resident #15 was interviewed on hispreferences of what days he would like to shower and at what times. Showerschedule updated to reflect his preferences. Resident #6 daughter was interviewedregarding preferences. The daughter indicatedthat she did not wish to make any changes regarding her care including whattime she gets up in the am.</p> <p>·how otherresidents having</p>	10/31/2014			

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	<p>a.m., Resident # 15 indicated, he only recieved showers on Mondays and Thursdays, however, if given the option he would take a shower daily. The resident indicated, sometimes he had not gotten a shower on his dedicated shower days and he had toured the unit wearing a sign to remind staff he needed a shower.</p> <p>A review of a document entitled, "Resident Preferences Sheet", received from the Director of Nursing Services, (DNS) on, 10/7/14, at 2:10 p.m., indicated when Resident #15 was assessed for showers he was only given the option to choose 2 days of the week on which to take showers. He was not given the option to take additional showers if he would have wanted them.</p> <p>2. Resident 6's record was reviewed on 10/6/14 at 2:02 p.m. Resident #6 had diagnoses which included, but were not limited to, Alzheimer's disease and dementia.</p> <p>During an interview on 10/1/14 at 12:52 p.m., Resident #6's daughter indicated Resident #6 did not get up according to her previous routine. She indicated her previous routine was to stay up late at night and sleep in in the morning. She indicated night shift got her mother out of bed before they left because it was convenient to them and no one had</p>		<p>the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken;</p> <p>Allresidents have the potential to be affected. All residents, including the Residents on the cottage, were interviewed on their preferences. The family was contacted if the Resident wasunable to voice their preference. Preferencesregarding what type of shower, how often they shower, and what time they wouldlike to get up in the am were reviewed. Schedules for showers and get up times were updated. DNS reviewed all resident preferences to makesure that we are following resident's choice. Nursing staff will be in-serviced October 28th by theDNS/designee to offer each resident a tub, bed bath or shower on the days andtimes they choose and also to honor Resident request regarding wake up times inthe am.</p> <p>-what measureswill be put in to place or what systemic changes will be made to ensure thatthe deficient practice does not recur;</p> <p>Nursing staff will be in-servicedOctober 28th by the DNS/designee to offer each resident a tub, bedbath or shower</p>				

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	<p>inquired about what her mother's previous routine preference was.</p> <p>A Minimum Data Set assessment tool (MDS), dated 2/14/14, indicated Resident #6 had cognitive impairment with a Brief Interview Mental Status score of 7 out of 15, it was very important to her to choose her own bed time, and to have family involved in discussions about her care.</p> <p>During an interview on 10/6/14 at 3:05 P.M., the Memory Care Coordinator indicated Resident #6 was on the night shift get up list.</p> <p>During an interview on 10/7/14 at 9:31 a.m., the Director of Nursing indicated the facility did not have a policy regarding the assessment of preferences but the facility did assess all residents for their preferences except the residents who resided on the memory care unit. She indicated the memory care unit provided care based on the daily request of the residents.</p> <p>3.1-3(u)(3)</p>		<p>on the days and times they choose and also to honor Resident request regarding wake up times in the am. All Residents, including Residents on the cottage, will be interviewed regarding preferences upon admission and quarterly. The family will be contacted regarding preferences if the Resident is unable to answer. Shower schedules and get up lists will be made according to the Residents preferences. Shower sheets will be filled out after shower/bath is given. Charge nurses check the shower schedule daily and review and sign the shower sheets completed on their shifts. The unit managers audit that showers/bathing is completed daily according to the Residents preference. During their rounds, the unit manager will ask the Residents if they were satisfied with their AM care including what time they got out of bed. Staff not in compliance with plan will receive further education and/or disciplinary action.</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;</p> <p>The Accommodation of Needs CQI tool will be completed weekly x 4 weeks, monthly x 6, and quarterly until continued compliance is</p>		

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F000280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to ensure family members were invited to participate in the comprehensive care plan conferences for 1 of 4 residents whose family was reviewed for participation in care plan conferences (Resident #6).</p> <p>Findings include:</p>	F000280	<p>maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p> <p>-what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice</p> <p>The family of resident #6 was invited to a care plan conference.</p> <p>-how other residents having</p>	10/31/2014

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	<p>Resident #6's record was reviewed on 10/6/14 at 2:02 p.m. Resident #6 had diagnoses which included, but were not limited to, Alzheimer's disease and dementia.</p> <p>During an interview on 10/1/14 at 12:52 p.m., Resident #6's daughter indicated she was not invited to participate in her mother's care plan conferences. She stated, "We get a care plan conference if we make a fuss about it..." She indicated they had been invited to one care plan conference "sometime in the summer" after they had complained about not being invited to care plan conferences.</p> <p>A Minimum Data Set assessment tool (MDS), dated 2/14/14, indicated Resident #6 had cognitive impairment with a Brief Interview Mental Status score of 7 out of 15 and it was very important to her to have family involved in discussions about her care.</p> <p>Care plan conference records held on 11/6/13, 2/19/14, 3/12/14, 5/21/14, and 8/5/14, were reviewed. The records lacked documentation Resident #6's family had been invited to and/or declined to attend care plan conferences in November 2013, February, March, and May of 2014.</p>		<p>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 have the potential to be affected. Social services staff will be inserviced by the Social Services Consultant on or by Oct. 28 regarding inviting the resident and family/responsible party to the care plan conference. All families that did not attend the past care plan meeting were contacted to inquire if the family would like to attend a care plan meeting. If so, a meeting was scheduled with the family.</p> <p>what measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur</p> <p>Social services staff will be inserviced by the Social Services Consultant on or by Oct. 28 regarding inviting the resident and family/responsible party to the care plan conference. The resident/responsible party will be invited to the care conference via mail or phone. The invitation will be documented in the resident's record. Social Services director will review care plan attendance documentation to ensure families were invited.</p>				

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F000282 SS=E	<p>During an interview on 10/6/14 at 3:39 P.M., the Memory Care Coordinator indicated Resident #6's family was at the facility everyday and didn't feel the need to be present for a formal sit down care conference. She indicated she "usually" would document in the record if family had been invited and if they chose to decline. During this interview the Memory Care Coordinator was asked to provide documentation Resident #6's family had been invited to and chose to decline or participate in her care plan conferences.</p> <p>During an interview on 10/7/14 at 9:31 a.m., the Director of Nursing indicated documentation was not available which indicated Resident #6's family had been invited to and/or declined to attend care plan conferences in November 2013, February, March, and May of 2014. The DON indicated the facility did not have a policy for "care plans" but it was the facility's practice to invite family members to residents' care plan conferences.</p> <p>3.1-35(a)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</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</p> <p>CarePlan Review CQI tool will be completed weekly x 4 weeks, bimonthly x 2 months, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>				

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	<p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observations, interview, and record review, the facility failed to ensure care plan interventions were implemented for 1 of 1 resident reviewed for dialysis, 1 of 3 residents reviewed for physician notification of death, 2 of 5 residents reviewed for nutrition, 1 of 3 residents reviewed for activities of daily living, and 1 of 3 residents reviewed for activity preferences (Resident #94, #105, #85, #18, #15, and Resident H).</p> <p>Findings include:</p> <p>1. On 10/06/14 at 12:39 p.m., resident # 94's record was reviewed. The care plan, dated 3/2/13, indicated the resident received hemodialysis and had a potential for complications. The care plan listed approaches to be taken to prevent complications including the resident would have hemodialysis on Tuesdays, Thursdays, and Saturdays, and staff would obtain and record the resident's blood pressure after he returned from dialysis.</p> <p>The physician order report, dated 9/9/14, indicated the resident's diagnoses included but were not limited to: hypotension post dialysis, renal dialysis,</p>	F000282	<p>-what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>Res # 94 blood pressure is beingobtained and documented. Resident H was not identified Res # 15 will be added to the one on oneactivity list Res #18 care plan updated to reflect hiscall light to be clipped to his shirt Res # 105 evaluated by RD and is nolonger has an order for Fortified Milk due to Resident preference Res # 85 all drinks will be served inthe modified cup indicated on her care plan</p> <p>-how otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken;</p> <p>All Residents have the potential to beaffected. All Residents who receive dialysisservices were reviewed by DNS ensure they have orders to obtain blood pressurewhen they return from dialysis. All Residents with daily weight orderswere reviewed by DNS for</p>	10/31/2014

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	<p>end stage renal disease, congestive heart failure, and intracerebral hemorrhage with history of cerebrovascular accident.</p> <p>The physician order, dated 2/22/13, indicated the resident had dialysis at a dialysis center on Tuesdays, Thursdays, and Saturdays.</p> <p>The physician telephone orders, dated 7/15/14, indicated the resident needed a nephrology consult to address his hypotension post dialysis. The physician telephone orders, dated 7/7/14, stated, "Please let them know that he is having decreased b/p (blood pressure) with dialysis maybe they can not take so much off!"</p> <p>The nursing progress note, dated 10/4/14 at 11:45 a.m., indicated the resident had returned from dialysis and his vital signs were blood pressure of 117/63 and pulse of 84.</p> <p>The nursing progress note, dated 9/27/14 at 12:32 p.m., indicated the resident had returned from dialysis, and no vital signs were recorded.</p> <p>The resident's blood pressure was not recorded after dialysis on the following days: 9/4/14, 9/6/14, 9/9/14, 9/25/14, and 9/27/14.</p>		<p>appropriate documentation of weights and notification. All Residents have been assessed by IDT team for their activity preference. Call lights are in reach of all Residents. All Residents who have meal time interventions were reviewed IDT team to ensure interventions in place. DNS/designee will in-service appropriate staff on or before Oct 28th on following the care plans for residents with daily weights, on dialysis services, who have meal time interventions, to ensure call lights are in reach, and activity preferences.</p> <p>-what measures will be put in to place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>DNS/designee will in-service appropriate staff on or before Oct 28th on following the care plans for Residents with daily weights, on dialysis services, who have meal time interventions, to ensure call lights are in reach, and activity preferences.</p> <p>Unit Managers will audit Mars daily to ensure weights and blood pressures are obtained/documented and proper notification is carried out per order.</p>				

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	<p>During an interview on 10/7/14 at 11:00 a.m., the director of nursing (DON) indicated there probably were no blood pressure recordings for the missing dialysis dates, but she would check the resident's records.</p> <p>During a follow up interview on 10/7/14 at 11:23 a.m., the DON indicated there were no blood pressures recorded for the missing dates. She indicated the staff was supposed to take the resident's blood pressure on those dates. She also indicated the resident had a plan of care to obtain the resident's blood pressure when he returned from dialysis, but it was not done.</p> <p>During an interview on 10/7/14 at 1:40 p.m., LPN #7 indicated she would assess a dialysis resident and take his or her blood pressure when he or she returned from dialysis. She indicated that resident #94 had recently returned from dialysis, and she had assessed him and took his vitals. She indicated she would chart his assessment and vitals by the end of her shift.</p> <p>2. Resident H's record was reviewed on 10/06/14 at 9:14 am. Resident H had diagnoses which included but were not limited to, edema, kidney failure, and chronic systolic heart failure.</p>		<p>Unit Managers and Customer Care Coordinators will observe for call lights in reach during their daily rounds. Any call lights found out of reach will be corrected immediately and proper education or disciplinary action will be carried out.</p> <p>Unit Managers and Customer Care Coordinators will ask Residents if their activity preferences are being met during their daily rounds. Any concerns that are voiced will be directed to the Activities Director for appropriate follow up.</p> <p>Nursing staff will check tray cards to ensure all items listed as preferences (which includes weight loss interventions and adaptive devices) are provided before tray is delivered to resident. Weight loss intervention checklist will be completed during each meal by RD/Designee for Residents receiving meal time interventions for weight loss, to monitor resident acceptance of interventions. Completed forms will be reviewed during NAR meeting. Any resident who experiences a pattern of refusal of the fortified foods; physician will be notified by DNS/Designee for alternative interventions.</p> <p>-how the corrective action(s)</p>				

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	<p>A physician's order, dated 5/9/14 at 3:00 p.m., indicated orders for staff to obtain Resident H's weights daily and to notify the physician of a two pound weight gain in one day or of a five pound weight gain in one week.</p> <p>Medication Administration Records (MAR) were reviewed for May 2014 and June 2014. The May 2014, MAR indicated Resident H's weight on May 31, 2014, was 205.1 pounds. The June 2014, Mar indicated Resident H's weight on June 1, 2014 was 214.8 pounds. The record lacked documentation which indicated the physician was notified of the 9.7 pound weight gain.</p> <p>During an interview on 10/7/14 at 1:15 p.m., the Director of Nursing (DON) indicated the record lacked documentation which indicated the weight was an error or staff followed the physician's order to notify him of a weight gain over two pounds in one day.</p> <p>3. A review of Resident # 15's chart, on 10/7/14 at 10:21 a.m., indicated he had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the facility had evaluated him to be cognitively intact.</p> <p>During an interview on, 10/3/14 at 9:55</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</p> <p>CarePlan Review CQI tool will be completed weekly x 4 weeks, monthly x 6, and quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved an action plan will be developed to assure compliance.</p>				

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	<p>a.m., Resident #15 indicated, the activities provided did not meet his interest because he enjoyed going outside, but is not given the opportunity to do so as often as he would like. Resident #15 indicated he enjoyed going out into the center courtyard, however he was not allowed to do so as often as he would like.</p> <p>During an interview on, 10/7/14 at 11:44 a.m., Activities Assistant #6, indicated she was aware Resident #15 enjoyed going outside. She indicated, there is a one on one list for residents who would like additional activities and one on one attention. She indicated this list of resident's were able to participate in activities that they preferred one on one with staff. She indicated Resident #15 was not currently on the one on one list and taken outside for one on one time.</p> <p>A review of Resident #15's care plan dated, 2/22/14, on 10/7/14, at 8:31 a.m., indicated his activities preferences included but were not limited to going out into the courtyard.</p> <p>4. A review of Resident #18's medical record, 10/6/14 at 11:40 a.m., indicated his Brief Interview for Mental Status (BIMS) score was 15 out of 15 on his 7/30/14 assessment indicating the facility</p>						

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	<p>had assessed him to be cognitively intact.</p> <p>During an observation on 10/6/14 at 2:38 p.m., Resident #18 indicated he had could not reach his call light. The resident was observed to be in his geri-chair (geriatric) at the side of his bed and his call light was in the bed wrapped in his sheets. Registered Nurse (RN) #2 was made aware of the situation and came into the room to assist the Resident. She indicated the resident's call light should be in reach at all times. The resident indicated he was not strong enough to push the button on the call light due to his illness. The RN indicated, she would get the resident a soft touch call light that better suited his needs.</p> <p>During an observation on, 10/7/14 at 8:50 a.m., Resident #18 was in his bed calling for help. His call light was observed to be under his body. The resident indicated he was unable to turn and reposition himself in order to retrieve the call light. Certified Nurse's Assistant (CNA) #3 was informed of the residents need for assistant. He entered the residents room at which time he retrieved the call light from underneath the residents back. CNA #3 indicated, the residents' call light should always be with him and used the clip attached to the call light to secure it</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
(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 to the residents shirt.</p> <p>A review of the residents care plans dated, 12/12/13 on, 10/6/14 at 3:02 p.m., indicated the resident was to have his call light within reach related to his high risk for falls.</p> <p>5. During a continuous observation on 10/6/14 from 1:23 p.m. until 1:45 p.m., Resident #105, was observed in bed, with her lunch tray sitting at her bedside. She indicated staff were supposed to come back and feed her. Her fortified milk was not observed to be on her tray at this time. Licensed Practical Nurse (LPN) #1 entered the room and assisted the resident with her lunch.</p> <p>During an interview with LPN#1 on 10/6/14 at 1:51 p.m., she indicated Resident #105 had been noted to have a decline in meal intake and she needed additional encouragement to eat. She reviewed the residents chart, and indicated the resident was supposed to receive fortified milk with her meals. She indicated the resident had not received the supplement on her tray and she would get one for her.</p> <p>A review of Resident #105's care plans dated, 9/5/14 on, 10/6/14 at 10:10 a.m., indicated the resident was to receive</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123		
(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>fortified milk with her meals.</p> <p>6. During an observation on 10/7/14 at 8:42 a.m., Resident # 85 was observed eating breakfast in the dining room. She was observed to have an orange juice served in a plastic cup with handles. The resident was observed to make continuous attempts to drink from the side of the cup, but was unable to do so due to her inability to steady the cup in her constantly shaking hands. Her milk remained in its opened carton. No plastic cup or straw was observed to be on the residents tray for her milk.</p> <p>During an interview on 10/7/14 at 9:22 a.m., RN #4, indicated, Resident #85, should have a modified cup or at least a straw for her milk because she has difficulty with intake due to her diagnosis. She indicated the resident's milk is usually poured into a modified cup.</p> <p>A review of Resident #85's care plans, dated 6/10/14, indicated she should have a plastic cup with handles and a straw at all meals.</p> <p>On 10/7/14 at 4:30 p.m. the Director of Nursing Services indicated she did not have a policy and procedure related to care plans.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2014
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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123
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F000325 SS=D	<p>This Federal tag relates to Complaint IN00155458</p> <p>3.1-3(u)(3)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview and record review the facility failed to ensure a system was in place to monitor residents' consumption of nutritional supplements being received with meals. This deficient practice affected 2 of 3 residents in the sample reviewed for nutritional status (#105, and 67).</p> <p>Findings include:</p> <p>1. During a stage one staff interview on, 10/2/14 at 2:30 p.m., Unit Manager #25, indicated Resident #105 was receiving nutritional supplements. She indicated consumption information for these supplements was not documented</p>	F000325	<p>-what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice; Res # 105 evaluated by RD and shedislikes Fortified Milk, Physician notified and discontinued order Resident likes whole milk and is provided two milks on each meal tray. Residents also receives fortified cereal at breakfast and fortified soup at lunch and dinner per physicians orders. Res # 67 evaluated by RD, noted weightgain, Physician notified and discontinued order</p> <p>-how otherresidents having the potential to be affected by the same deficient practicewill be identified and what</p>	10/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
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	<p>separately from meal intake information.</p> <p>During a continuous observation on, 10/6/14 from 1:23 p.m. until 1:45 p.m., Resident #105, was observed in bed, with her lunch tray sitting at her bedside. She indicated staff was supposed to come back and feed her. Her fortified milk was not observed to be on her tray at this time. Licensed Practical Nurse (LPN) #1 entered the room and assisted the resident with her lunch.</p> <p>During an interview with LPN#1 on, 10/6/14 at 1:51 p.m., she indicated Resident #105 had been noted to have a decline in meal intake and she needed additional encouragement to eat. She reviewed the residents chart, and indicated the resident was supposed to receive fortified milk with her meals. She indicated the resident had not received the supplement on her tray and she would get one for her.</p> <p>A review of Resident #105's care plans on, 10/6/14 at 10:10 a.m., indicated the resident was to receive fortified milk with her meals.</p> <p>During an interview on, 10/07/2014 1:41 p.m., the Director of Nursing Services (DNS) indicated, nurses were not expected to chart consumption of</p>		<p>corrective action(s) will be taken; All Residents with meal timeinterventions have the potential to be affected. All Residents with meal timeinterventions were reviewed to verify interventions are still appropriate. Dietary Manager/designee will in-servicedietary staff on or before Oct 28th to ensure meal timeinterventions are on tray according to their care plan. DNS/designee will in-service nursing staff onthe need to check the tray card to ensure all items listed as preferences (which includes weight loss interventionsand adaptive devices) are provided before tray is delivered to resident.</p> <p>-what measureswill be put in to place or what systemic changes will be made to ensure thatthe deficient practice does not recur; Dietary Manager/designee will in-servicedietary staff on or before Oct 28th to ensure meal timeinterventions are on tray according to their care plan. DNS/designee will in-service nursing staff onthe need to check the tray card to ensure all items listed as preferences (which includes weight loss interventionsand adaptive devices) are provided before tray is delivered to resident. Weightloss intervention checklist will be completed during each meal by RD/Designee</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
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	<p>fortified foods. She indicated consumption records for these foods were charted along with the total meal consumption by the Certified Nurse's Assistants (CNA). She indicated the nurses were to verify the residents had the fortified food on their trays when the trays were passed. She indicated there was no method to make sure the resident consumed the fortified items.</p> <p>2. During a stage one staff interview on, 10/2/14 at 2:30 p.m., Unit Manager #25, indicated Resident #67 was receiving nutritional supplements. She indicated consumption information for these supplements was not documented separately from meal intake information.</p> <p>Resident # 67 was observed in the dining room on, 10/7/14 at 12:52 p.m., with his fortified milk in a cup in front of him. At 1:21 p.m. the resident's was removed from the dining room and his fortified milk remained untouched.</p> <p>A review of Resident #67's orders on, 10/7/14 at 12:30 p.m., indicated, the resident was to receive fortified foods with meals.</p> <p>During an interview on, 10/07/2014 1:41 p.m., the Director of Nursing Services (DNS) indicated, nurses were not</p>		<p>for Residentsreceiving meal time interventions for weight loss, to monitor resident acceptanceof interventions. Completed forms will be reviewed during NAR meeting. Anyresident who experiences a pattern of refusal of the fortified foods; physicianwill be notified by DNS/Designee for alternative interventions.</p> <p>-how thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place;</p> <p>Mealtime observation CQI tool will be completed weekly x 4weeks,monthly x6, and quarterly until continued compliance is maintained for 2consecutive quarters. The results of these audits will be reviewed by the CQIcommittee overseen by the ED. If threshold of 100% is not achieved an actionplan will be developed to assure compliance.</p>				

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
(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			
F000364 SS=E	<p>expected to chart consumption of fortified foods. She indicated consumption records for these foods are charted along with the total meal consumption by the Certified Nurse's Assistants (CNA). She indicated the nurses were to verify the residents had the fortified food on their trays when the trays were passed. She indicated there was no method to make sure the resident consumed the fortified items.</p> <p>This Federal tag relates to Complaint IN00155458.</p> <p>3.1-46(a)(2)</p> <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. Based on interview and observation, the facility failed to ensure residents were served food that was palatable and at the proper temperatures. This deficient practice affected 5 of 12 residents reviewed for food palatability and proper temperatures (Residents #236, #146, #218, #1, and #15).</p> <p>Findings include:</p>	F000364	<p>-what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice; Residents # 236, 146,218, 15, and 1 will receive food at palatable and appropriate temperatures.</p> <p>-how otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be</p>	10/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123		
(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>1. During an interview on 10/02/2014 at 12:59 p.m., Resident #236 indicated the food was not served at the proper temperatures. She indicated it was either cold or luke warm and breakfast was consistently "bad."</p> <p>2. During an interview on 10/07/14 at 9:40 a.m., Resident #146 indicated the she was often served food that was not palatable or at the proper temperatures.</p> <p>3. During an interview on 10/02/14 at 1:16 p.m., Resident #218 indicated the food was not always served at the proper temperatures.</p> <p>4. During an interview on 10/1/14 at 11:39 a.m., Resident #1 indicated the food was usually "lukewarm."</p> <p>5. During an interview on 10/3/14 at 10:15 a.m., Resident # 15 indicated, the food he received in the dining room was always cold. He indicated he had told staff they needed to get a heat lamp or something to keep the food hot. He indicated the soup is always cold if he ordered it with his meal. He indicated, the only time he got hot soup was when he ordered it as a substitute item.</p> <p>A review of Resident # 15's chart, on 10/7/14 at 10:21 a.m., indicated he had a</p>		<p>taken; All Residents have the potential to beaffected. Dietary staff will be in serviced by theDietary Manager on or before Oct 28th on monitoring and documenting foodtemperature. Dietary staff will take temperatures at the beginning of mealservice, during meal service and at the end of meal service to ensureacceptable ranges of temperatures during portioning, transporting and serviceprocess until received by the resident.</p> <p>-what measureswill be put in to place or what systemic changes will be made to ensure thatthe deficient practice does not recur; Food temps are checked daily at thebeginning, during and end of each meal and recorded on a food temperature logby food service personnel to ensure that foods are served at the appropriatetemperature. The log will be reviewed byDietary Manager/ designee. DietaryManager/Designee will review temperature logs at each meal and if food does notmeet requirements, corrective action will be taken.</p> <p>·Residents will be interviewed weekly to inquire regarding food palatability by customer care reps. Any concerns will be addressed by RD.</p> <p>-how thecorrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance</p>		

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
(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>Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the facility had evaluated him to be cognitively intact.</p> <p>During an interview on 10/07/14 at 2:10 p.m., the Activity Director (AD) indicated the Food Quality Council was separate from the Resident Council. She indicated residents would occasionally mention complaints regarding food palatability and/or temperature at the Resident Council meetings but those complaints were encouraged to be voiced at the food council meeting and were not documented in the Resident Council minutes.</p> <p>The Food Advisory Committee Meeting notes for the previous 6 months were reviewd on 10/7/14 at 3:30 p.m. The Food Advisory Committee met on the following dates:</p> <p>The Food Advisory Committee Meeting notes, dated 6/4/14, indicated residents complained about food not being served at proper temperatures.</p> <p>The Food Advisory Committee Meeting notes, dated 6/20/14, indicated residents complained about food palatability.</p> <p>The Food Advisory Committee Meeting</p>		<p>program will be put into place; To ensure compliance, the DietaryManager/Designee is responsible for the completion of the Test Tray MonitoringTool daily for 4 weeks, then weekly thereafter to ensure continued complianceis maintained. The results will bereviewed by CQI Committee overseen by the ED.</p>				

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
(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			
F000441 SS=E	<p>notes, dated 7/22/14, indicated residents complained about food palatability.</p> <p>The Food Advisory Committee Meeting notes, dated 9/27/14, indicated residents had complained about food palatability.</p> <p>During an observation on 10/7/14 at 8:06 a.m., the Dietary Manger obtained food temperatures from a breakfast test tray. The following temperatures were noted: 1) Orange juice- 50 degrees. 2) Carton of milk-53 degrees.</p> <p>A policy titled "Food Temperatures" identified as current by the Dietary Manager on 10/7/14 at 8:52 a.m., indicated, "...All hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food..."</p> <p>This Federal tag relates to Complaint IN00155458</p> <p>3.1-21(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>						

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
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	<p>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. Based on observation and interview, the facility failed to sanitize/wash hands before and/or after resident to resident contact or contact with resident surroundings during a medication administration observation. This deficient practice had the potential to</p>	F000441	-what correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice; Residents # 58, 241, 102, 188, and 143did not have any adverse affects related to the alleged deficient practice. Residentsare receiving	10/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
(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>affect 5 of 5 residents observed during medication administration observation (Resident #58, #241, #102, #188, and #143)</p> <p>Findings include</p> <p>Continuous observations of LPN #9 were made on 10/7/14 beginning at 7:10 a.m. and ending at 7:40 a.m.</p> <p>On 10/7/14 at 7:10 a.m., LPN #9 was observed pushing Resident #58 in her wheel chair from the resident's bathroom to the resident's side of the room. LPN #9 picked up a Kleenex and handed it to Resident #58. LPN #9 then removed a bottle of eye drops from her scrub pocket and walked over to Resident #102 LPN #9 sat sat the medication bottle and a clear medicine cup which contained oral medication on Resident #102's bed. LPN #9 re-position Resident #102. LPN #9 picked the medication bottle up off the bed and opened the bottle and removed the eye drops. She then administered eye drops into Resident #102's eye. She put the bottle of eye drops back into the medication bottle and placed the bottle back into her scrub pocket. She then picked up the cup of oral pills from the bed and administered the oral medications to Resident #102. LPN #9 returned to Resident #58 and</p>		<p>medications per policy.</p> <p>-how otherresidents having the potential to be affected by the same deficient practicewill be identified and what corrective action(s) will be taken; All Residents have the potential to be affected. All staffed in-serviced by DNS/designee on or before October 28, 2014 on proper hand sanitation during med pass. DNS/designee will complete a medicationpass skills validation observation for licensed nursing staff.</p> <p>-what measureswill be put in to place or what systemic changes will be made to ensure that thedeficient practice does not recur;</p> <p>·All staffed in-serviced by DNS/designee on or before October 28, 2014 on proper hand sanitation during med pass.</p> <p>·DNS/designee will complete a medicationpass skills validation observation for licensed nursing staff. Clinical Education Coordinator/designee willround daily and observe medication pass on various shifts to ensure proper handhygiene is occurring.</p> <p>-how thecorrective action(s) will be monitored to ensure the deficient practice willnot recur,i.e., what quality assurance programwill be put into place; The DNS/designee</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155792		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 10/07/2014	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS				STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123			
(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>administered her oral medications. LPN #9 then returned to Resident #102's bedside and took her cup of fluids from her and placed it on the bedside table. LPN #9 walked out of the room, picked up a pen off of the medication cart, and documented in the Medication Administration Record (MAR). LPN #9 prepared Resident #188's medications. LPN #9 knocked and entered Resident #188's room. She handed her a cup of pills and then took a medication bag out of her scrub pocket. LPN #9 opened the bag and removed an inhaler. She handed the inhaler to Resident #188. Resident #188 handed the inhaler back to LPN #9. LPN #9 put the inhaler back into the medication bag. LPN #9 returned to the medication cart, opened the cart, returned the inhaler back to to cart, picked up a pen, and documented in the MAR. LPN #9 began preparing Resident #241's medication. LPN #9 reached into her scrub pocket and removed a cell phone. She placed the cell phone on the medication cart. She flipped through the MAR pages and continued to prepare more medications. LPN #9 used her finger to push through an aluminum seal to open a bottle of generic Miralax. While LPN #9 was waiting for Resident #241 to finish using the bathroom Resident #143 asked for clean linens. LPN #9 sat Resident #241's eye drops</p>		<p>will complete amedication pass skills validation tool for 5 nurses (at least 1 from eachshift) each week for 4 weeks, 5 nurses each month x6, and 5 nurses quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will bereviewed by the CQI committee overseen by the ED. If threshold of 100% is notachieved an action plan will be developed to assure compliance.</p>				

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NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 762 N DAN JONES RD AVON, IN 46123
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(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
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	<p>and medication cup on top of the clean linen cart. LPN #9 reached into the clean linen cart and removed clean linens. She handed Resident #143 clean linens. LPN #9 removed her jacket, scratched her left forearm, then repositioned her necklace. She picked up the eye drops and cup of medication from off of the clean linen cart and placed both into a chair next to Resident #241. She then physically assisted Resident #241's with drinking fluids to take her oral medications. Resident #241 dropped a medication and LPN #9 picked it up off of the floor. LPN #9 then used her bare hand to pull down Resident #241's lower eye lid, administered an eye drop, picked up a Kleenex, and wiped off Resident #241's eye. LPN #9 then returned to the medication cart, opened the cart, returned the medications, and began to document in the MAR.</p> <p>LPN #9 was not observed to wash/sanitize or use gloves during this continuous observation.</p> <p>During an interview on 10/7/14 at 7:40 a.m., LPN #9 indicated she "probably" should have worn gloves when she administered eye drops and she failed to do so. She indicated she was "supposed" to clean her hands between residents and she failed to do so.</p>			
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	<p>A policy titled "Medication Pass Procedure" identified as current by the Clinical Education Coordinator on 10/7/14 at 11:30 a.m., indicated, "...Mediations are opened without contaminating... hands washed following administered (gel x 5 then water) unless resident contact then washes hands after..."</p> <p>A policy title "Hand Hygiene" identified as current by the Clinical Education Coordinator on 10/7/14 at 11:30 a.m., indicated, "...5 Moment of required hand hygiene: Before patient, Before an aseptic task, After body fluid exposure risk, After patient contact, After contact with patient surroundings..."</p> <p>3.1-18(1)</p>			