STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155258	A. BUILDING 00 B. WING	06/24/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00436406, IN00436038, IN00436070, IN00434644 and IN00437112 . Complaint IN00436406 - No deficiencies related to the allegations are cited. Complaint IN00436038 - No deficiencies related to the allegations are cited. Complaint IN00436070 - No deficiencies related to the allegations are cited. Complaint IN00434644- No deficiencies related to the allegations are cited. Complaint IN00437112 - Federal/State deficiency related to the allegations are cited at F609. Unrelated deficiencies are cited. Survey dates: June 21 and 24, 2024 Facility number: 000160 Provider number: 155258 AIM number: 100267190 Census Bed Type: SNF/NF: 74 SNF: 3 Total: 77 Census Payor Type: Medicare: 13 Medicaid: 49 Other: 15 Total: 77	F 0000	The plan of correction is to serve as Countryside's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Countryside or its management company that the allegations contained in the survey report are 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. The facility respectfully requests desk review for the following citations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Keeshan Patel	Executive Director	07/08/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed June 26, 2024.			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility	F 0609	The plan of correction is to serve	07/09/2024

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	failed to report an incident of a resident leaving the facility and the facility being unsure of her whereabouts for 1 of 1 resident reviewed for an unusual occurrence. (Resident C) Findings include: Resident C's clinical record was reviewed on 6/24/24 at 10:27 a.m. Diagnoses included unspecified severe protein-calorie malnutrition, adult failure to thrive, difficulty in walking, type II diabetes mellitus without complications, history of falling, attention and concentration deficit following other cerebrovascular disease, and other speech and language deficits following other cerebrovascular disease. Orders included insulin lispro (short acting) insulin per sliding scale three times daily, metformin (treat diabetes) 750 mg twice daily, mirtazapine (treat depression) 7.5 mg daily, acetaminophen (treat pain) 1000 mg three times daily, and cleanse coccyx wound with wound cleanser, pat dry, apply Medihoney (for wound healing) to wound bed and cover with a foam dressing every Monday, Wednesday and Friday. An admission Minimum Data Set (MDS) assessment, dated 6/5/24, indicated the resident was severely cognitively impaired. She required the assistance of two staff members for bed mobility, transfers and toilet use. She was frequently incontinent of bowel and bladder. She had two emergency contact relatives. She did not have a Power of Attorney (POA) or guardian. A nurses note, dated 6/20/24 at 1:58 a.m., indicated Resident C returned from the hospital at 1:30 a.m. via private automobile, accompanied by a		as Countryside's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Countryside or its management company that the allegations contained in the survey report are 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. The facility respectfully requests desk review for the following citations. **F 609 Reporting Allegations** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** No residents were negatively affected by the alleged practice. **II. The facility will identify other residents that may potentially be affected by the practice.** No other residents were negatively affected by the alleged practice. **III. The facility will put into**	

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	family member. Resident C was treated for hyperglycemia (high blood sugar) and an altered mental status. The hospital administered insulin at 9:45 p.m., due to her blood sugar being over 400 mg/dL. She was assisted to her room, provided peri care and changed into a nightgown. Vital signs were obtained, and a head-to-toe assessment was completed with no new injuries or skin issues found. A social service note, dated 6/20/24 at 10:42 a.m., indicated the social worker met with Resident C for a psychosocial visit in the common area as she watched TV and ate breakfast. Resident C was asked how she was doing, and she stated good. She was able to carry a conversation and was very pleasant. A nurses note, dated 6/20/24 at 11:41 a.m., indicated Resident C stated she was afraid due to the incident that happened the day prior and asked staff not to hurt her. She was ensured she would not be hurt intentionally in the building by anyone. The clinical record lacked indication as to why the resident had been at the hospital, or when/how she had left the facility. During an interview with Resident C's Emergency Contact 2, on 6/24/24 at 11:22 a.m., he indicated on 6/19/24 around 3:30 p.m. to 4:00 p.m., a family member took Resident C out of the facility and intended to keep her. The family member told CNA 17 that she was going to take Resident C and CNA 17 realized something was wrong and reported it. Resident C was taken to the hospital because her blood sugar had spiked. The hospital released her between 1:00 a.m. to 1:30 a.m. and she came back to the facility.		**place the following systematic changes to ensure that the practice does not recur.** The Administrator and Director of Nursing are being educated on the timeliness and appropriate reporting of allegations. **IV. The facility will monitor the corrective action by implementing the following measures.** The Clinical Specialist or designees will review that allegations are reported appropriately and timely. These results will be discussed at the monthly facility Quality Assessment Performance Improvement meeting monthly for 6 months and then quarterly once compliance is at 100%. The frequency and duration of reviews will be increased as needed if compliance is below 100% **V. Plan of Correction completion date.** Date of Compliance 7/9/2024	

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	During an interview with the Administrator, on 6/24/24 at 12:19 p.m., he indicated Resident C's family member came into the facility on 6/19/24 and visited Resident C in the activity room for 5 to 10 minutes. The family member was going to take Resident C to her room but went to the parking lot instead. Another resident, sitting outside, saw the family member struggling to get Resident C into her car and let the receptionist know. The receptionist called the nurses station and CNA 17 was sent up front to help. CNA 17 asked Resident C's family member how long she was going to be gone and if she signed out. The family member indicated they were going for a drive a would be right back, which prompted CNA 17 to tell the ADON. The facility tried to contact the other family members and let them know that this family member had taken Resident C out of the building, and they indicated she was not supposed to leave with that family member. The facility contacted the family member who took Resident C in her car, and she indicated she had no intention of bringing Resident C back to the facility. The ADON called the police per the family request. He did not report the incident to the Indiana Department of Health because Resident C was with a family member. At the current time, no one was allowed to take Resident C out of the building until a POA was established. During an interview with CNA 17, on 6/24/24 at 2:02 p.m., she indicated around 4:00 p.m., on 6/19/24, Receptionist 9 called the nurses station to assist Resident C into the family member's car. CNA 17 went outside to the family member's car. The family member indicated her shoes were slippery and she couldn't get Resident C into the car. Resident C pointed to the facility and indicated she was going home. CNA 17 assisted			

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	Resident C into the car. The family member indicated to Resident C you don't have to take this sh-- anymore or sit in the activity room watching the f---king Dukes of Hazard. CNA 17 observed that Resident C had been incontinent and she was wet. She asked the family member if she would like the CNA to provide care and the family member indicated she would change the residents' brief when she got her home. CNA 17 walked back into the facility and reported what the family member said to Receptionist 9 and the Director of Marketing and Admissions. During an interview with the Director of Marketing and Admissions, on 6/24/24 at 2:52 p.m., she indicated she had been in her office and CNA 17 was going out to the parking lot to assist Resident C in getting in a car. The person had taken Resident C from the activity room and took her outside. The way the family member took the resident outside and the comments about how she could take better care of the resident at home alerted her to do something about that person taking Resident C. Initially, they were not sure who had taken Resident C. They went back to Resident C's room to see if her belongings were still in her room, and they were. On her nightstand was a name and telephone number, so they looked up the name on social media and CNA 17 indicated that was the same person she helped get Resident C into her car. If it wasn't for finding the name and phone number on Resident C's nightstand, they would not had known who Resident C left with. She had seen a cognitive decline in Resident C since she was admitted to the facility. Herself, Receptionist 9 and the ADON called her two emergency contact relatives and the Administrator, who came to the facility. The ADON called the police. The police were able to identify the car Resident C left in, through video			

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	footage at a gas station, but the license plate did not match the car. A current facility policy, titled "Incident Reporting Policy for Indiana Communities," indicated the following: "...B. The following incidents must be reported to the Indiana State Department of Health as soon as possible after an allegation is made or the incident occurred, but minimally must be reported within 24 hours ...4. Occurrences that directly threaten the welfare, safety, or health of a resident ...d. Elopement of a resident ...ii. Whose whereabouts had been unknown or whose return to the Community involves law enforcement or emergency personnel...." This citation relates to Complaint IN00437112. 3.1-28(c)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide			

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	separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medication carts were kept locked when unattended, and failed to ensure proper labeling of medications for 2 of 3 carts observed for medication storage on the 200 Hall. Findings included: On 6/24/24 at 3:12 p.m., the two medication carts on the Southeast 2 unit were observed to be unlocked and unattended by staff. Residents were observed in the hallways and in the lounge area at this time. During an interview on 6/24/24 at 3:17 p.m., RN 1 indicated the nurse (LPN 2) responsible for the medication cart had stepped off the unit. She indicated the nurse also had the keys for the 2nd (overflow) medication cart. The overflow medication cart contained oral pills. The top drawer contained oral pills (identified as 19 melatonin (supplement for sleep) and 8 potassium chloride 10 meq) without resident indicators. RN 1 indicated she did not know why theses medications were not in a box with a resident's name or identifiers. During an interview on 6/24/24 at 3:22 p.m., LPN 2 she would normally lock the medication cart when she walked away from it. The top drawer of the	F 0761	The plan of correction is to serve as Countryside's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Countryside or its management company that the allegations contained in the survey report are 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. The facility respectfully requests desk review for the following citations. **F 761 Labeling of Drugs and Biologicals** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The medication carts on 200 hall	07/09/2024

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	medication cart contained breathing treatments, nasal sprays, eye drops, oral pills, insulin pen needles and lancets. Drawers 2-7 included all oral medications (pills). The 8th drawer (bottom drawer) contained patches, liquids, breathing treatments. The top drawer to the right contained insulin pens. The second drawer contained locked narcotic drawer. The 3rd drawer down on the right contained various liquid medications and powdered medications. The bottom drawer on the right contained povidone iodine solution (skin antiseptic) and cleaning wipes. A current undated policy, titled "Drug Storage," and provided by the Administrator on 6/24/24 at 4:14 p.m., indicated the following: "...Medications are dispensed in containers that meet or exceed official standards. These containers will be stored orderly in a secured area accessible to pharmacy personnel and to licensed nursing personnel designated by the facility per resident care policies. .... Procedure .... 3. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access...." 3.1-25(m)		were locked and medications labeled appropriately. **II. The facility will identify other residents that may potentially be affected by the practice.** Other medication carts were observed to ensure they were locked and medications were labeled appropriately. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Nurses and Qualified Medication Aides are being educated regarding medication storage including locking medication carts and proper labeling. **IV. The facility will monitor the corrective action by implementing the following measures.** The Director of Nursing or designees will review that medication and treatment carts are being locked and medications are labeled properly daily for 4 weeks, weekly for 8 weeks then quarterly ongoing. These results will be discussed at the monthly facility Quality Assessment Performance	

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			Improvement meeting monthly for 6 months and then quarterly once compliance is at 100%. The frequency and duration of reviews will be increased as needed if compliance is below 100% **V. Plan of Correction completion date.** Date of Compliance 7/9/2024	