| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 155258 | A. BUILDING 00<br>B. WING | 01/03/2025 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00449493.<br><br>Complaint IN00449493- No deficiencies related to the allegations were cited.<br><br>Survey dates: December 26, 27, 30, 31, 2024 and January 2 and 3, 2025<br><br>Facility number: 000160<br>Provider number: 155258<br>AIM number: 100267190<br><br>Census Bed Type:<br>SNF/NF: 64<br>SNF: 8<br>Total: 72<br><br>Census Payor Type:<br>Medicare: 19<br>Medicaid: 45<br>Other: 8<br>Total: 72<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed January 9, 2025. | F 0000 | The plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.<br><br>Submission of this plan of correction does not constitute an admission by Countryside Manor House 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.<br><br>The facility respectfully requests desk review for the following citations. | |
| F 0686<br>SS=D<br>Bldg. 00 | 483.25(b)(1)(i)(ii)<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>Based on observation, interview, and record review, the facility failed to ensure completion of wound care treatment as ordered to promote healing of a pressure injury for 1 of 3 residents | F 0686 | **F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer**<br><br>**I. What corrective actions will** | 01/20/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Brandon Estep | HFA | 01/17/2025 |

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| | reviewed for pressure injuries. (Resident 63)<br><br>Finding Includes:<br><br>Resident 63's clinical record was reviewed on 12/30/24 at 11:04 a.m. Diagnoses included an unspecified fracture of lower end of right femur, unspecified disorder of the skin and subcutaneous tissue, and end stage renal disease.<br><br>A quarterly Minimum Data Set (MDS) assessment, dated 11/8/24, indicated the resident did not have any pressure injuries, was occasionally incontinent of bowel and bladder, required partial staff assistance for bed mobility, and did not transfer to utilize the toilet.<br><br>A current care plan, dated 11/13/24, indicated Resident 63 was at risk for skin breakdown. Interventions included to assist with bed mobility (11/23/24), turn and reposition per resident's needs (11/13/24), and monitor skin for signs of breakdown (11/13/24).<br><br>The clinical record lacked a care plan for pressure injury.<br><br>A current physician order, dated 11/13/24, indicated to apply Resinol (a skin protectant and topical analgesic) to affected areas on each buttocks twice daily, upon rising and at bedtime.<br><br>A wound management note, dated 12/4/24, indicated an abrasion to the coccyx measuring 1.0 centimeter (cm) length by 1.0 cm width.<br><br>A late entry wound management note, dated 12/11/24 and initiated on 12/27/24, indicated an abrasion to the coccyx measuring 1.0 cm length by 1.0 cm width. | | **be accomplished for those residents found to have been affected by the practice?**<br><br>Wound care treatment was completed per order for Resident 63.<br><br>**II. The facility will identify other residents that may potentially be affected by the practice.**<br><br>Other residents with pressure injuries were observed to ensure completion of the ordered wound care treatment.<br>**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**<br>Licensed nurses are being educated regarding completion of ordered wound care treatments.<br><br>**IV. The facility will monitor the corrective action by implementing the following measures.**<br><br>The DON, or designee, will audit residents with pressure injuries for completion of ordered wound care treatments daily for 4 weeks, then weekly for 8 weeks, then monthly for 3 months, then quarterly ongoing.<br><br>The results of these reviews will be | |

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| | The clinical record lacked additional wound management notes for the coccyx abrasion.<br><br>A "Skin Integrity Event", dated 12/7/24, indicated a pressure injury to the coccyx, measuring 0.5 cm length by 0.3 cm width by 0.1 cm depth.<br><br>A current physician order, dated 12/7/24, indicated to clean the upper coccyx wound with normal saline and apply Medi-honey (to treat wounds) to wound bed and cover, daily on the day shift.<br><br>A progress note, dated 12/25/24, indicated Resident 63 had a continued treatment to the coccyx wound.<br><br>During a wound observation, on 12/31/24 at 2:16 p.m., LPN 2 and RN 3 entered the resident's room for wound care. LPN 2 and RN 3 utilized hand sanitizer and donned appropriate personal protective equipment (PPE). The resident independently rolled onto her right side. The coccyx wound was uncovered. LPN 2 applied Resinol to the open area, directly on a bony prominence, roughly the size of a #2 pencil eraser, circular, with a white edged open area. LPN 2 did not measure the area. The resident's buttocks had no visible redness.<br><br>This observation is inconsistent with the previous wound management note dated 12/11/24.<br><br>During an interview, at the time of the wound observation, LPN 2 indicated the DON had looked at the wound earlier that morning. The DON removed the dressing, measured the wound, and planned to document the wound was healed. Resident 63 indicated the DON had been in her | | discussed at the monthly facility Quality Assurance Committee meeting monthly for no less than 6 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br><br>**V. Plan of Correction completion date.**<br>January 20th, 2025 | |

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| | room earlier and did measure her coccyx wound.<br><br>During an interview, on 12/31/24 at 2:47 p.m., the DON indicated she saw Resident 63 today, removed her coccyx dressing and measured her wound. The current measurements were 0.2 cm length by 0.2 cm width with no depth, (roughly the size of a pencil point). The cream utilized by LPN 2 was just a barrier cream. The DON was not aware of the Medi-honey order. The staff member that completed the original skin integrity event and medication order was on vacation and unable to be reach by phone. The DON indicated the staff completed weekly skin assessments and but only completed "Skin Integrity Events" for new open areas.<br><br>A current facility policy, revised on 1/29/21, titled, "Skin Risk Policy", provided by the DON on 1/3/25 at 11:25 a.m., indicated the following: "CarDon & Associates, Inc. and its members are committed to providing quality care to our residents which includes identifying residents who are at risk for compromised skin integrity and preventing the development or worsening of skin issues... Addition interventions to prevent development or worsening of wounds/open area include:... Obtaining and following MD prevention/treatment order..."<br><br>A current facility policy, dated 4/3/17, titled, "Protocol for Following Physician Orders", provided by the DON on 1/3/25 at 9:12 a.m., indicated the following: ".. It is the policy of CarDon and associates that we will provide the appropriate physician prescribed care to the residents in our communities...All licensed staff will verify and follow the physician orders as written. | | | |

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| F 0880 SS=D Bldg. 00 | 3.1-40<br><br>483.80(a)(1)(2)(4)(e)(f)<br>Infection Prevention & Control<br><br>Based on observation, interview, and record review, the facility failed to follow infection prevention and control procedures related to contact isolation (additional precautions used when standard precautions may not be enough to stop the spread of infection) precautions for 2 of 3 resident reviewed for transmission-based precautions. (Resident 61 and 227)<br><br>Finding includes:<br><br>1. During an observation, on 12/27/24 at 2:09 p.m., Resident 227 was lying in bed and indicated she had been in the facility for roughly five days. She was going to the gym for therapy. On the door to Resident 227's room was an orange Contact Precautions sign, and three (3) signs with directions on putting on and taking off personal protective equipment (PPE). The PPE was hanging on the door inside plastic dividers. The dividers contained gowns, gloves, face masks, and face shields.<br><br>During an observation, on 12/30/24 at 2:19 p.m., Resident 227 was being propelled in her wheelchair down the hallway towards her room, by PTA 4. PTA 4 and Resident 227 entered the room together. PTA 4 situated Resident 227 in her wheelchair at the foot of the bed, off to the side. PTA 4 retrieved wheelchair foot pedals from inside the room and using her bare hands attached them to the wheelchair. PTA 4 asked the resident to remain in her wheelchair for 20 more minutes and attached the call light to the mechanical lift pad underneath the resident. | F 0880 | **F 880 \|Infection Prevention & Control**<br><br>**I. What corrective actions will be accomplished for those residents found to have been affected by the practice?**<br><br>PTA 4, CNA 5, LPN 6 and CNA 7 were educated regarding contact isolation precautions.<br><br>**II. The facility will identify other residents that may potentially be affected by the practice.**<br><br>Staff are following infection prevention and control procedures for other residents requiring contact isolation precautions.<br>**III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**<br>Direct care staff members are being educated regarding contact isolation precautions.<br><br>**IV. The facility will monitor the corrective action by implementing the following measures.**<br><br>The IP/DON, or designee, will | 01/20/2025 |

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| | Resident 227 remained seated in the wheelchair. Resident 227 indicated she thought she needed to have a bowel movement and was not going to be able to wait until staff could help her. PTA 4 straightened the residents bed sheets. Without washing her hands, PTA 4 donned a gown and gloves. PTA 4 indicated she couldn't find a bed pad in the room. PTA 4 doffed the gown and gloves and exited the room. PTA 4, using her soiled hands, utilized the key pad to open the storage closet door across the hall. While in the hallway, PTA 4 was stopped by visitors wanting to exit, and walked the visitors to the exit doors at the end of the hallway. PTA 4, using her soiled hands, utilized the key pad to open the exit doors at 2:27 p.m. No hand washing or hand sanitization was observed at any time during these activities.<br><br>During an observation, on 12/30/24 at 2:35 p.m., CNA 5 entered the room to answer the call light for Resident 227. Resident 227 asked for a tissue, the CNA grabbed the box of tissues on the dresser by the door and placed them on the resident's bedside table. CNA 5 moved the bedside table from the head of the bed to the foot of the bed, directly beside the resident as she sat bedside in her wheelchair. The resident requested assistance in getting back into bed. CNA 5 indicated she couldn't find bed pads in the room. CNA 5 exited the room and with her soiled hands, utilized the key pad to open the supply closet. CNA 5 removed two bed protection pads and closed the supply closet door. CNA 5 re-entered Resident 227's room and placed the pads onto her bed. CNA 5 indicated she would get the mechanical lift and someone to help her. CNA 5 exited the room. CNA 5 did not don PPE, nor performed hand sanitization or hand washing during these activities. | | observe 3 staff members providing care for residents requiring contact isolation precautions to ensure compliance with infection control practices daily for 4 weeks, then weekly for 8 weeks, then monthly for 3 months, then quarterly ongoing.<br><br>The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for no less than 6 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100%.<br><br>**V. Plan of Correction completion date.**<br>January 20th, 2025 | |

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| | During an interview, at the time of the observation, CNA 5 indicated the isolation sign required staff to wear PPE when entering a resident's room. This isolation sign could have been for different reasons and these reasons could have been found in the residents clinical record.<br><br>Resident 227's clinical record was reviewed on 12/30/24 at 2:34 p.m. Diagnoses included recurrent enterocolitis due to Clostridium difficile (a germ that causes diarrhea and colitis [an inflammation of the colon] and can be life-threatening), unspecified diarrhea, and pneumonitis due to inhalation of food and vomit.<br><br>A current physicians order, dated 12/13/24, indicated to follow contact isolation with meals, activities, therapy. All services must be provided in room with isolation precautions followed.<br><br>An Admission Minimum Data Set (MDS), dated 12/16/24, indicated Resident 227 had a diagnosis of Clostridium difficile and was dependant on staff for personal and toileting hygiene and toilet transfers.<br><br>A current care plan, dated 12/13/24, indicated the resident required contact isolation related to a diagnosis of Clostridium difficile. Interventions included provide contact isolation supplies (i.e. personal protective equipment etc.) and to provide staff, resident, and family education regarding contact isolation precautions as needed.<br><br>During an interview, on 12/30/24 at 3:03 p.m., PTA 4 indicated when therapy staff worked with Resident 227 in the resident's room, they would wear a gown and gloves. When Resident 227 was | | | |

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| | brought to the gym, the staff did not wear PPE since the condition was able to be contained.<br><br>During an interview, on 12/30/24 at 3:58 p.m., LPN 2 indicated contact precautions were used when a resident had an infection or open wound and the facility needed to prevent the spread of this infection. Resident 227 had a diagnosis of Clostridium difficile. This diagnosis required staff to wear PPE while in the resident's room and utilize soap and water for handwashing after exiting the resident room.<br><br>2. During an observation, on 12/30/24 at 10:48 a.m., Resident 61's room had an orange contact precautions sign, and three (3) signs with directions on putting on and taking off PPE. The PPE was hanging on the door inside plastic dividers. The dividers contained gowns, gloves, face masks, and face shields.<br><br>During an observation, on 12/31/24 at 8:58 a.m., two staff members entered a room to deliver lunch meal trays. CNA 7 placed a tray to the bedside table of the resident farthest from the door. LPN 6 placed a tray onto the bedside table of Resident 61, closest to the door. LPN 6 utilized the resident's bed remote to lift the head of the bed to 90 degrees. LPN 6 placed her right hand on the right side grab bar attached to the resident's bed as she set up the lunch tray for Resident 61. CNA 7 and LPN 6 did not don PPE nor perform hand sanitization or hand washing upon exiting.<br><br>During an interview, at the time of the observation, LPN 6 indicated she should have paid closer attention to the sign and recognized the difference between an Enhanced Barrier Precautions sign and the Contact Precautions signs. She and CNA 7 should have donned | | | |

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| | gowns and gloves prior to entering the room and when leaving should have doffed the PPE and washed their hands with soap and water immediately.<br><br>Resident 61's clinical record was reviewed on 12/31/24 at 8:55 a.m. Diagnoses included Enterocolitis due to Clostridium difficile, unspecified diarrhea, and end stage renal disease.<br><br>A current physician order, dated 12/27/24, indicated to follow contact isolation with meals, activities, and therapy. All services must be provided in room with isolation precautions followed.<br><br>A quarterly Minimum Data Set (MDS), dated 12/5/24, indicated Resident 61 was incontinent of bowel and bladder and dependent on staff for toileting hygiene and showering. The resident did not transfer to utilize the toilet.<br><br>A current care plan, dated 12/27/24, indicated the resident required contact isolation related to a diagnosis of Clostridium difficile. Interventions included provide contact isolation supplies (i.e. personal protective equipment etc.) and to provide staff, resident, and family education regarding contact isolation precautions as needed.<br><br>During an interview, on 1/3/25 at 10:00 a.m., the Therapy Supervisor indicated a resident with a Clostridium difficile diagnosis or the possibility of Clostridium difficile could go to the therapy gym. The staff checked to ensure the resident was wearing a clean brief and the resident's clothing was clean. When therapy was completed, the staff utilized a 1:10 bleach solution to clean all the equipment used. If the resident become | | | |

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| | incontinent during the therapy session, the therapy session ended and the resident was returned to their room immediately.<br><br>During an interview, on 1/3/25 at 11:45 a.m., UM 9 indicated when a resident had a diagnosis or had signs and symptoms of Clostridium difficile, they were placed in contact precautions to prevent the spread of infections. The staff were educated on how to enter and exit rooms with contact precautions. The signs and PPE were placed on the appropriate resident doors. Staff would don PPE prior to entering the room, when the care was completed, the staff removed the PPE inside the room, opened the door, and then used soap and water to wash their hands. The hand washing would take place inside the resident room as long as the outside door had been opened. The staff would utilize soap and water to wash their hands outside the room as well. The resident specific reason for contact precautions would be found in the resident medical record, but this information would also be exchanged during the "walking rounds" performed from shift to shift. Isolation precautions had been covered in facility in-services.<br><br>During an interview, on 1/3/25 at 12:55 p.m., the DON indicated the expectation for staff was for the isolation precautions to be followed. When a resident had a diagnosis of Clostridium difficile, they would require contact isolation precautions and those included utilizing soap and water for handwashing. The information was covered in facility in-services. The last all staff in-service was in April 2024. The facility had started another staff education after the observations during the current survey. The facility followed the Contact Precautions policies and procedure found on the Centers for Disease Control and Prevention (CDC) | | | |

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| | website.<br><br>An online reference titled, "Transmission Based Precautions" (4/3/24), retrieved on 1/6/25 from https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html indicated the following: "... Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens..."<br><br>A facility policy, reviewed 1/2024, titled, "Clostridioides Difficile (C-Diff) Policy", provided by the DON on 12/31/24 at 1:46 p.m., indicated the following: "...A resident with a suspected or known active care of C-Diff that has been confirmed must be placed in contact isolation because C-Diff is transmitted by direct and indirect contact. This means the resident and the environment can cause others to contract the same infection..."<br><br>3.1-18(b)(2)<br>3.1-18(l) | | | |