

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

PRINTED: 05/14/2025
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155258		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/11/2025	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE MANOR HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP COD 205 MARINE DR ANDERSON, IN 46016			
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00453043.</p> <p>Complaint IN00453043 - Federal/state deficiencies related to the allegations are cited at F656.</p> <p>Survey date: April 11, 2025</p> <p>Facility number: 000160 Provider number: 155258 AIM number: 100257190</p> <p>Census Bed Type: SNF/NF: 78 Total: 78</p> <p>Census Payor Type: Medicare: 6 Medicaid: 53 Other: 19 Total: 78</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed April 21, 2025.</p>			F 0000	<p>The plan of correction is to serve as Countryside's credible allegation of compliance.</p> <p>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.</p> <p>The facility respectfully requests desk review for the following citations.</p> <p>F 656 Develop/Implement Comprehensive Care Plan</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the practice.</p> <p>Involved staff member no longer works at the facility.</p> <p>II. The facility will identify other residents that may potentially be affected by the practice.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Brandon Estep

Administrator

05/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosable 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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			<p>Other staff members are following facility protocol and care plan interventions while utilizing mechanical lifts during transfers of dependent residents.</p> <p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur.</p> <p>Direct care nursing staff are being educated regarding following care plan interventions and facility protocol while utilizing mechanical lifts during transfers of dependent residents.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>The DON, or designee, will observe 5 depenedent residents being transferred utilizing a mechanical lift to ensure compliance with facility protocol and individual care plan interventions weekly for 12 weeks, then quarterly ongoing.</p> <p>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</p>		

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F 0656 SS=D Bldg. 00	<p>483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan</p> <p>Based on interview and record review, the facility failed to ensure staff followed resident care plan interventions and facility protocol while utilizing a mechanical lift during a transfer of a dependent resident for 1 of 4 residents reviewed for accidents. (Resident B)</p> <p>Findings include:</p> <p>Resident B's clinical record was reviewed on 4/11/25 at 10:40 a.m. Diagnoses included hemiplegia and hemiparesis following cerebrovascular disease affecting right dominant side, diabetes mellitus, hypertension, dysphagia, and chronic kidney disease.</p> <p>The most current Significant Change Minimum Data Set (MDS) assessment, dated 3/18/25, indicated the resident was depended for toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, chair/bed-to-chair transfer, and tub/shower transfer.</p> <p>A current care plan titled "CNA Assignment Sheet Resident has specific needs related to their care", dated 11/09/22, had an intervention dated 11/09/22, of the resident is assisted with two person assist and hoyer (mechanical) [lift] with</p>	F 0656	<p>will be increased as needed if compliance is below 100%</p> <p>V. Plan of Correction completion date.</p> <p>Date of Compliance April 21, 2025</p> <p>The plan of correction is to serve as Countryside's credible allegation of compliance.</p> <p>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.</p> <p>The facility respectfully requests desk review for the following citations.</p> <p>F 656 Develop/Implement Comprehensive Care Plan</p> <p>I. The corrective actions to be accomplished for those residents found to have been affected by the practice.</p>	04/21/2025	

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	<p>transfers. This intervention was last edited on 2/10/25.</p> <p>Review of a facility self- reportable, dated 2/9/25 indicated, on 2/8/25, the resident experienced pain and heard a "popping" sound. An x-ray was obtained and determined a subtle nondisplaced supercondylar fracture of the right elbow. The reportable did not mention any staff member or situation that may have been involved.</p> <p>A progress note, dated 2/7/25 at 9:34 p.m., indicated the resident complained of pain in the right shoulder while CNAs were utilizing a mechanical stand up lift for resident transfer to the bed. Range of motion resulted in no pain. The resident complained of pain while the shoulder was stationary.</p> <p>The facility investigation included an Administrator interview statement by QMA 1, dated 2/8/25, that indicated they had attempted to transfer the resident with the mechanical stand up lift without assistance of another staff member. The resident complained of pain in the right shoulder and the QMA immediately terminated the transfer and sought out assistance from CNA 2. The QMA informed LPN 3 of the resident's pain.</p> <p>QMA 1 was not available for interview during the survey on April 11, 2025 .</p> <p>Review of an Administrator interview statement by CNA 2, dated 2/10/25, indicated QMA 1 had requested assistance transferring the resident. When CNA 2 arrived to the resident's room, the resident was complaining of shoulder pain. QMA 1 and CNA 2 transferred the resident to a wheelchair and then to the bed. During the</p>				<p>Involved staff member no longer works at the facility.</p> <p>II. The facility will identify other residents that may potentially be affected by the practice.</p> <p>Other staff members are following facility protocol and care plan interventions while utilizing mechanical lifts during transfers of dependent residents.</p> <p>III. The facility will put into place the following systematic changes to ensure that the practice does not recur.</p> <p>Direct care nursing staff are being educated regarding following care plan interventions and facility protocol while utilizing mechanical lifts during transfers of dependent residents.</p> <p>IV. The facility will monitor the corrective action by implementing the following measures.</p> <p>The DON, or designee, will observe 5 depenedent residents being transferred utilizing a mechanical lift to ensure compliance with facility protocol and individual care plan interventions weekly for 12 weeks, then quarterly ongoing.</p>		

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	<p>transfer, the resident did not complain. Once the resident was in bed they indicated the shoulder felt better while they were in bed.</p> <p>During an interview on 4/11/25 at 1:52 p.m., CNA 2 indicated QMA 1 had the resident in the lift before she requested her assistance. The resident said the QMA had put her in the stand up lift and her shoulder started hurting. QMA 1 put her back in the recliner and when CNA 2 came into the room, the resident was hooked up to the lift but was already in her recliner. "I never saw Michele operate the lift or anything". CNA 2 indicate the resident preferred the stand up lift. CNA 2 indicated staff were supposed to have two people when operating any mechanical lift, as it had always been that way.</p> <p>During an interview on 4/11/25 at 3:16 p.m., CNA 4 indicated the resident required a mechanical lift because it became too difficult to stand. The resident used to use her left hand to hang on to the rails, but she could not do that any longer. CNA 4 had never used a stand-up lift for the resident's transfers, as she would feel safer using the mechanical lift.</p> <p>During an interview on 4/11/25 at 3:33 p.m., the DON indicated staff should always use two persons for any mechanical lifts. The facility did not have a policy dedicated to mechanical lift safety.</p> <p>A current copy of staff education related to mechanical lift transfers was provided by the DON on 4/11/25 at 2:00 p.m.. The education indicated the following: "...REMINDER...All mechanical equipment such as Hoyer Lift or Stand Up Lift MUST be utilized with the assistance of at least 2 people. You cannot use these by yourself. Failure</p>				<p>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%</p> <p>V. Plan of Correction completion date.</p> <p>Date of Compliance April 21, 2025</p>		

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	to comply will result in disciplinary action. This is for the resident and associate's safety...You must check your assignment sheets to verify resident transfer status. Theses can be found on the iPads. If you need assistance with this, please notify your supervisor or ADON (name). Do not solely go off what the resident or staff tell you. Verify by reviewing the assignment sheet." This citation relates to complaint IN00453043. 3.1-37(a)						