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	12/04/2023

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 a Recertification and State Licensure Survey. Survey dates: November 27, 28, 29, 30, and December 1 & 4, 2023 Facility number: 000160 Provider number: 155258 AIM number: 100267190 Census Bed Type: SNF/NF: 65 SNF: 6 Total: 71 Census Payor Type: Medicare: 5 Medicaid: 54 Other: 12 Total: 71 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 6, 2023.	F 0000	The plan of correction is to serve as Countryside Manor Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Countryside Manor Health and Living 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. The facility respectfully requests desk review for this survey.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	12/04/2023

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
	(ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.			
	Based on interview and record review, the facility failed to resolve resident council concerns related to call lights being turned off prior to assistance and long call light wait times. (Residents 2, 9, 10, 16, 20, 38, 49, 54 and 73) Findings include: During the Resident Council meeting on 11/29/23 at 2:35 p.m., Residents 2, 9, 10, 16, 20, 38, 49, 54	F 0565	**F 565 Resident/Family Group and Response** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The facility has reviewed the concerns regarding call light	12/21/2023

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	12/04/2023

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
	and 73 indicated the wait for call lights to be answered was long, and staff would turn off the call light without completing care. During an interview on 11/27/23 at 10:58 a.m., Resident 67 indicated the call light wait time ranged from 1 to 2 hours, with the average being around an hour. During review of the resident council minutes, on 11/28/23 at 9:57 a.m., the following was observed: The 8/23/23 minutes indicated residents were concerned about the call light issues not being addressed, and the resident council meeting was the only place to voice a grievance. The record lacked a facility follow-up. The 9/25/23 minutes indicated residents were concerned about staff turning call lights off prior to providing care and long call light wait times of over an hour. The record lacked a facility follow-up. The 10/25/23 minutes indicated residents were concerned about long call light wait times. Resident 10 indicated wait times over 1 hour. The record lacked a facility follow- up. During an interview on 12/1/23 at 2:03 p.m., the Social Services Director (SSD) indicated she had not received grievance forms from the resident council meetings, as Resident Council concerns were handled during the meetings. During an interview on 12/1/23 at 2:55 p.m., the Administrator indicated the facility did not have a call light time log or any print out indicating call light response times.		response times and initiated an action plan to resolve the concerns. **II. The facility will identify other residents that may potentially be affected by the practice.** Other concerns from resident council are being reviewed and resolved. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The Activities Director is being educated on the grievance procedure. The resident council members are being educated on the grievance procedure. **IV. The facility will monitor the corrective action by implementing the following measures.** The Administrator, or designee, will review resident council concerns to ensure resolution and response monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once	

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	12/04/2023

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
	During an interview on 12/4/23 at 10:56 a.m., the Activities Director (AD) indicated she utilized the "Resident/Family Concern/Grievance Form," when resident council members present concerns during the meeting. She provided the Administrator with these forms for review and completion. During an interview on 12/4/23 at 10:59 a.m., the Administrator indicated the resident council grievances or concerns were not documented on grievance forms, and the concerns voiced in the resident council meetings were handled immediately and documented on the "Resident Council Minutes" forms. A current, revised 12/06, facility admission policy, provided by the Administrator on 11/30/23 at 11:46 a.m., titled "Resident Council", indicated the following: "...7. A "Resident Council Response Form" will be utilized to track issues and their resolution. The facility department related to any issues will be responsible to address the item(s) of concern...." 3.1-3(1)		compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance : 12/21/23 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0582 SS=E Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for			

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	12/04/2023

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
	those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission			

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	12/04/2023

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
	to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide notification of Medicare non-coverage for 3 of 3 residents reviewed for beneficiary protection notifications. (Resident 68, 185, and 71) Findings include: On 11/28/23 at 2:25 p.m., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed, and indicated the following: 1. Resident 68 had admitted to the facility on 4/28/23 under Medicare Part A Skilled Services. The last covered day of Part A Services was 8/5/23. The resident remained in the facility. The clinical record lacked both Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) and the Notice of Medicare Non-coverage (NOMNC) notices. 2. Resident 185 had admitted to the facility on 8/4/23 under Medicare Part A Skilled Services. The last covered day of Part A Services was 10/12/23. The resident discharged home on 10/13/23. The clinical record lacked a NOMNC notice. 3. Resident 71 had admitted to the facility on 8/26/23 under Medicare Part A Skilled Services. The last covered day of Part A Services was 10/31/23. The resident remained in the facility. The clinical record lacked both SNF ABN and the NOMNC notices. During an interview on 11/30/23 at 1:47 p.m., the Social Services Director (SSD) indicated the	F 0582	**F 582 Medicaid/Medicare Coverage/Liability Notice** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** Resident 68, 185 and 71 have received the beneficiary protection notifications. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents have been reviewed for beneficiary protection notifications and have received notifications if indicated. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The Social Services Director and Business Office Manager have been educated regarding the beneficiary protection notifications. **IV. The facility will monitor the corrective action by implementing the following measures.** The Administrator, or designee,	12/21/2023

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	12/04/2023

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
	residents 68 and 71 should have received the SNF ABN and NOMNC form, and a NOMNC form should have been provided to Resident 185. Review of "Beneficiary Notices Really Can Be Understood" (April 6, 2021), retrieved on 12/5/23 at 12:31 p.m. from the American Association of Post-Acute Care Nursing (AAPACN) website indicated the following: "...The Basics....Under federal and state laws, Medicare beneficiaries have rights while residing in the nursing home, to help ensure that a beneficiary receives the care and services they need. One of these rights is to be informed when care and services will most probably not be covered by their Medicare benefits. The nursing home must inform the resident of the decision to end skilled care and the option to appeal...." 3.1-4(f)(2) 3.1-4(f)(3)		will review residents discharging from Medicare Part A skilled services to ensure they have received beneficiary protection notifications weekly for 12 weeks, then monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance : 12/21/23 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents,			

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	12/04/2023

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
	and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance			

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	12/04/2023

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
	process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey			

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	12/04/2023

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
	Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on record review and interview, the facility failed to educate resident council members on the facility grievance process. (Residents 9, 16, 20, 38, 54, and 73) Findings include: During the Resident Council meeting on 11/29/23 at 2:30 p.m., residents 9, 16, 20, 38, 54, and 73 indicated they did not know the grievance process or how to file a grievance. During a record review on 11/28/23 at 9:57 a.m., the resident council binder lacked a record of grievances filed. During an interview on 11/30/23 at 9:25 a.m., the Administrator indicated there were no grievances from the resident council meetings and the Social Services Director (SSD) was the facility's grievance designee. During an interview on 12/1/23 at 2:03 p.m., the SSD indicated she has not received grievance forms from the resident council meetings, as Resident Council concerns were handled during the meetings. During an interview on 12/4/23 at 10:56 a.m., the Activities Director (AD) indicated she utilized the "Resident/Family Concern/Grievance Form," when resident council members present concerns during	F 0585	**Facility has additional information to present regarding the IDR.** **F 585 Grievances** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The resident council members are being educated on the facility grievance process. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents in the facility have been educated on the facility grievance process. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** The Activities Director has been educated on the facility grievance process.	12/21/2023

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	12/04/2023

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
	the meeting. She provided the Administrator with these forms for completion. During an interview on 12/4/23 at 10:59 a.m., the Administrator indicated the resident council grievances or concerns were not documented on grievance forms, and the concerns voiced in the resident council meetings were handled immediately and documented on the "Resident Council Minutes" forms. A current, revised 12/06, facility admission policy, provided by the Administrator on 11/30/23 at 11: 46 a.m., titled "Resident Council", indicated the following: "...b. Assisting in the development of resident grievance and complaint procedures; ... 7. A "Resident Council Response Form" will be utilized to track issues and their resolution...." 3.1-7(b)		**IV. The facility will monitor the corrective action by implementing the following measures.** The Administrator, or designee, will review all resident council concerns to ensure the grievance process is followed monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance : 12/21/23 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
F 0636 SS=E Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.			

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	12/04/2023

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
	§483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a			

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	12/04/2023

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
	comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure comprehensive assessments were completed per the Resident Assessment Instrument (RAI) specified timeline. (Resident 63, 38, 47, 79 and 287) Findings include: 1. Resident 63's clinical record was reviewed on 11/28/23 at 2:10 p.m. Current diagnosis included acute renal failure, aphasia, and dysphagia. The resident had a 10/17/23 significant change Minimum Data Set (MDS). The assessment was signed by the MDS Coordinator on 11/08/23 (22 days after the assessment date). This resulted in the assessment being signed eight days late. During an interview on 12/4/23 at 10:57 a.m., the MDS Coordinator indicated Resident 63's MDS was signed late due to the lack of an MDS assistant during that time period and the inability to complete all tasks in a timely manner. 2. Resident 38's clinical record was reviewed on 11/28/23 at 2:14 p.m. Current diagnosis included end stage renal disease, complete traumatic	F 0636	**F 636 Comprehensive Assessments & Timing** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The facility has completed the comprehensive assessments for Resident 63, 38, 47, 79, and 287. **II. The facility will identify other residents that may potentially be affected by the practice.** Other residents are being reviewed for timely completion of comprehensive assessments. MDS assistant has been hired. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.**	12/21/2023

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	12/04/2023

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
	amputation of left lower leg, and diabetes mellitus. The resident was readmitted to the facility 9/25/23. The resident had a 9/28/23 Admission MDS which was not signed until 10/18/23 (20 days after the assessment date). The signature was six days later than the required 14 day period. During an interview on 12/4/23 at 10:58 a.m., the MDS Coordinator indicated she had needed assistance completing all the tasks of the MDS process due to the loss of her assistant. At times during that time period, MDS assessments were signed late. 3. Resident 47's clinical record was reviewed on 11/30/23 at 9:09 a.m. Current diagnosis included unspecified cerebral infarction, influenza virus with other respiratory manifestations, attention and concentration deficit following other cerebrovascular disease, memory deficit following other cerebrovascular disease, and obstructive and reflux uropathy. The resident had a 10/19/23 Admission MDS which was not signed until 11/7/23 (20 days after the assessment date). The signature was six days later than the required 14 day period. 4. Resident 79's clinical record was reviewed on 11/30/23 at 11:24 a.m. Current diagnosis included cellulitis of left lower limb, Methicillin Resistant Staphylococcus Aureus (MRSA) infection as the cause of diseases classified elsewhere, and morbid (severe) obesity due to excess calories. The resident had a 10/30/23 Admission MDS which not signed until 11/9/23 (16 days after the assessment date). The signature was two days later than the required 14 day period. 5. Resident 287's clinical record was reviewed on		Staff are being educated regarding the timely completion of comprehensive assessments and resources available for assistance if needed. **IV. The facility will monitor the corrective action by implementing the following measures.** The MDS coordinator, or designee, will review comprehensive assessments for timeliness weekly for 12 weeks, then monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance : 12/21/23 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	

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	12/04/2023

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
	11/30/23 at 2:08 p.m. Current diagnosis include acute and chronic respiratory failure with hypoxia, weakness, other chronic pain and chronic obstructive pulmonary disease with (acute) exacerbation (COPD). The resident has a 11/13/23 Admission MDS which was not signed until 11/29/23 (17 days after the assessment date). The signature was three days later than the required 14 day period. During an interview on 11/30/23 at 3:56 p.m., the MDS Coordinator indicated she utilized the RAI manual found online and was aware some of the assessments where completed late. She was the only employee in this role and required an assistant to be able to complete the MDS tasks on time. Review of the current online RAI manual (November 23, 2023) retrieved from www.cms.gov on 12/5/23 indicated the following: "...MDS completion date no later than the 14th calendar day from the assessment reference date (ARD)...." 3.1-31(d)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including			

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	12/04/2023

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
	procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were reconciled per facility policy for 2 of 3 medication carts reviewed for medication storage. (41 South cart and 41 North cart) Findings include: 1. During a medication storage observation of the 41 South cart, accompanied by LPN 6 on 12/4/23 at 11:10 a.m., the "Nurse's Narcotic Sign In/Out Sheet" record was reviewed and the following dates lacked shift to shift reconciliation of controlled medications: In November 2023- 11/2 on day and evening shifts,	F 0755	**F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The 41 South cart and 41 North cart are reconciling narcotics per policy. **II. The facility will identify other residents that may potentially be affected by the practice.**	12/21/2023

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	12/04/2023

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
	11/3 on day shift, 11/4 on night shift, 11/8 on day and night shifts, 11/13 on night shift, 11/15 on day and evening shifts, 11/16 on day and evening shifts, 11/18 on evening and night shifts, 11/19 on day shift, and 11/30 on day shift. 2. During a review of the 41 North cart, "Nurse's Narcotic Sign In/Out Sheet" record, provided by the DON on 12/4/23 at 12:10 p.m., the following dates lacked shift to shift reconciliation of controlled medications: In November 2023- 11/1 on day shift, 11/4 on all three shifts, 11/5 on day shift, 11/10 on day shift, 11/11 on day shift, 11/12 on day shift, 11/14 on evening shift, 11/16 on day shift, 11/18 on evening and night shifts, 11/19 on day shift, 11/23 on evening shift, 11/26 on day shift, and 11/29 on day shift. During an interview on 12/4/23 at 12:07 p.m., the DON indicated the expectation of the nursing staff was the narcotic sign in/sign out sheet to be completed at any time the medication cart keys change hands. An undated, current facility policy titled "Controlled Substance Reconciliation," provided		Other medication carts are being reviewed to ensure reconciliation of narcotics per policy. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed nurses and qualified medication aides are being educated on the reconciliation of narcotics. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will review reconciliation records on medication carts weekly for 12 weeks, then monthly for 3 months, then quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance : 12/21/23	

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	12/04/2023

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
	by the Corporate Nurse Consultant on 12/4/23 at 12:45 p.m., indicated the following: "...1. Each facility should verify the quantity of controlled substance(s) on hand as well as the number of accompanying "count sheets" at the end of each nursing shift...." 3.1-25(b)(3)		The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	
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 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 and interview, the facility failed to appropriately label medications brought	F 0761	**F 761 Label/Store Drugs and Biologicals**	12/21/2023

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	12/04/2023

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
	in to the facility by the resident or resident family and stored in the medication cart in 1 of 3 medication carts. (34 South Hall medication cart) Findings include: On 12/4/23 at 11:30 a.m., during observation of the 34 South Hall medication cart, accompanied by LPN 5, the following was observed: a. Four bottles of Omega XL 300 mg (milligram) (dietary supplement), lacked a resident name or pharmacy label. b. On bottle of D3 5000 units (vitamin supplement), lacked a resident name or pharmacy label. c. Sleep XL (dietary supplement), lacked a resident name or pharmacy label. During an interview at the time of observation, LPN 5 indicated there was no resident name or prescribing information on the bottles. Review of current, undated facility policy titled, "Medication Labeling," provided by the Nurse Consultant on 12/4/23 at 12:34 p.m., indicated the following: "...Procedure...8. Over the counter medications used for a specific resident must identify that resident and have an appropriate pharmacy label applied...." 3.1-25(j)		**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** The medication sin 34 south hall medication cart have been labeled appropriately. **II. The facility will identify other residents that may potentially be affected by the practice.** Other medication carts have been reviewed for appropriate labeling. **III. The facility will put into place the following systematic changes to ensure that the practice does not recur.** Licensed nurses and qualified medication aides are being educated on required labels on medications brought in by families/residents. **IV. The facility will monitor the corrective action by implementing the following measures.** The DON, or designee, will audit medication carts for appropriate labeling weekly for 12 weeks, then monthly for 3 months, then quarterly ongoing.	

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	12/04/2023

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
			The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter once compliance is at 100%. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. **V. Plan of Correction completion date.** Date of Compliance : 12/21/23 The Administrator will be responsible for ensuring the facility is in compliance by date of compliance listed.	