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	10/04/2022

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. This visit included the Investigation of Complaint IN00390818 and IN00386962. Complaint IN00390818 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00386962 - Substantiated. No deficiencies related to the allegations were cited. Survey dates: September 27, 28, 29, 30, October 3 and 4, 2022 Facility number: 000160 Provider number: 155258 AIM number: 100267190 Census Bed Type: SNF/NF: 55 SNF: 3 Total: 58 Census Payor Type: Medicare: 6 Medicaid: 45 Other: 7 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 6, 2022	F 0000	The plan of correction is to serve Countryside Manor Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Countryside Manor 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 provision constitute an agreement or admission of the survey allegations. **The facility respectfully requests desk review for the following citations.**	
F 0623 SS=D	483.15(c)(3)-(6)(8) Notice Requirements Before			

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

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Bldg. 00	Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this			

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	section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.			

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	§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to provide notice of transfer to residents or their representative for 2 of 4 residents reviewed. (Resident 20, and Resident 33) Findings include: 1. A review of Resident 20's clinical record was completed on 10/3/22 at 2:10 p.m. He was transferred to the emergency room on 8/18/22 for aggressive and uncooperative behaviors. He was admitted with a urinary tract infection. There was no record of transfer/discharge information having been given to the resident or his legal representative at the time of the transfer. 2. A review of Resident 33's clinical record was completed on 9/28/22 at 2:22 p.m. He was transferred to the emergency room on 9/19/22 due	F 0623	**F623 Notice Requirements Before Transfer/Discharge S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Residents 20 and 33 have been discharged. **II. The facility will identify other residents that may potentially be affected by practice.** · Other residents that have transferred/discharged in the last 7 days have been reviewed for notice	10/26/2022

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	to low hemoglobin blood level as reported by the dialysis provider. There was no record of transfer/discharge information being provided to the resident or his legal representative at the time of transfer. During an interview on 10/3/22 at 2:18 p.m., the Director of Nursing (DON) indicated the record lacked transfer/discharge information for Resident's 20 and 33 related to their transfers to the emergency room. She indicated the information should have been completed. A current facility policy, dated 6/4/19, titled, "Discharge Planning," provided by the Corporate Nurse Consultant on 9/30/22 at 4:24 p.m., included, but the following: "Policy Interpretation and Implementation: XIV. If a resident is discharged to the care of another health care entity such as a hospital...., the community shall providde the receiving entitiy with the following.....F. All other necessary information to ensure a safe and effective transistion of care." 3.1-12(a)(21)		of transfer. A notice of transfer has been provided if indicated. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · Licensed nurses are being educated regarding providing notice of transfer to residents or their representatives. **IV. The facility will monitor the corrective action by implementing the following measures.** · The DON or designees will review discharges and transfers to ensure the Notice of Transfer was provided to the residents or their representatives. This will be done daily for 4 weeks, weekly for 8 weeks, followed by quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 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**	

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			correction completion date. · Date of compliance: October 26, 2022 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.	
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist			

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	the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to develop a discharge summary to ensure a safe discharge and continuity of care for 2 of 3 residents reviewed. (Resident 58 and Resident 60) Findings include: 1. Resident 58's clinical record review was completed on 9/30/22 at 11:37 a.m. The resident was discharged on 8/5/22. Diagnoses included, but were not limited to the following, syncope and collapse, chronic kidney disease stage 3, long term (current) use of anticoagulants, need for assistance with personal care and age-related cognitive decline. The clinical record lacked a discharge summary and discharge instructions. An order, dated 8/3/22, indicated to discharge the resident with physical therapy, occupational therapy, and home health care. A Nurse's Note, dated 8/5/22, indicated the resident discharged home with his daughter. A care plan to return home after rehabilitation, dated 7/12/22, indicated the resident would have discharge arrangements made prior to the discharge date. Interventions included, resident would have services or equipment arranged prior to/upon discharge per physician order. During an interview on 9/30/22 at 11:18 a.m. the	F 0661	**F661 Discharge Summary S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Residents 58 and 60 have discharged. **II. The facility will identify other residents that may potentially be affected by practice.** · Other residents that have transferred/discharged in the last 7 days have been reviewed for development of a discharge summary. If indicated, a summary has been provided. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · Licensed nurses and social services are being educated regarding development of	10/26/2022

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	Director of Nursing (DON) indicated the discharge summary and discharge instructions were under observations in the clinical record. During an interview on 9/30/22 at 3:08 p.m., the DON indicated she did not know of any other location to find the discharge summary and discharge instructions. A copy of the resident's discharge summary and discharge instructions were requested at this time. During an interview on 9/30/22 at 3:35 p.m., the Registered Nurse (RN) Consultant indicated the resident's discharge summary was not developed and the clinical record lacked a discharge summary or discharge instructions. A second request was made for the resident's discharge summary and discharge instructions. Further documentation was not provided. During an interview on 9/30/22 at 4:20 p.m., the RN Consultant indicated since the discharge summary and discharge instructions were not in the clinical record, the facility did not have a record of what documents were provided at discharge. During an interview on 10/3/22 at 11:01 a.m. the RN Consultant indicated the resident did not discharge against medical advice. 2. Resident 60's clinical record review was completed on 9/30/22 at 9:49 a.m. The resident was discharged on 8/11/22. Diagnoses included, but were not limited to, encounter for surgical aftercare following surgery on the digestive system, type 2 diabetes mellitus with hyperglycemia, hyperlipidemia, essential hypertension, difficulty in walking, not elsewhere classified, pain, unspecified and vitamin		discharge summaries. **IV. The facility will monitor the corrective action by implementing the following measures.** · The DON or designees will review all discharges to ensure development of a discharge summary. This will be done daily for 4 weeks, weekly for 8 weeks, followed by quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 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: October 26, 2022 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.	

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	deficiency, unspecified. The clinical record lacked a discharge order, discharge summary, and discharge instructions. Review of a Social Service Note, dated 8/11/22 at 11:31 a.m., indicated the resident was discharging home with his sister and father on 8/11/22. The planned discharge time was 4:00 p.m. A Nurse's Note, dated 8/11/22 at 5:47 p.m., indicated the resident was discharged. A care plan to return home independently after rehabilitation, dated 8/8/22, indicated the resident would have discharge arrangements made prior to the discharge date. Interventions included the resident would have services or equipment arranged prior to/upon discharge per physician order. During an interview on 9/30/22 at 3:08 p.m., the DON indicated the discharge summary and discharge instructions were not availabe for review. A copy of the resident's discharge summary and discharge instructions were requested at this time. During an interview on 9/30/22 at 3:35 p.m., the Register Nurse (RN) Consultant indicated the resident's discharge summary was not developed and the clinical record lacked a discharge summary or discharge instructions. A second request was made for the resident's discharge summary and discharge instructions. Further documentation was not provided. During an interview on 9/30/22 at 4:20 p.m., the RN Consultant indicated since the discharge summary and discharge instructions were not in the clinical record, the facility did not have a record of what			

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	documents were provided at discharge. During an interview on 10/3/22 at 11:01 a.m. the RN Consultant indicated the resident did not discharge against medical advice and the clinical record lacked an order to discharge the resident. A current policy, titled "Discharge Planning," provided by the RN Consultant on 9/30/22 at 4:24 p.m., indicated the following: " ... I. When the community anticipates a resident's discharge to a private residence... a discharge summary and a post-discharge plan will be developed which will assist the resident to adjust to his or her living environment. II. The discharge summary will include a recapitulation of the resident's stay at this community and a final summary of the resident's status at the time of the discharge in accordance with established regulations... XIII. A copy of the following will be provided to the resident and any receiving provider and a copy will be filed in the resident's medical records: A. An evaluation of the resident's discharge needs; B. The post-discharge plan; and C. The discharge summary...." 3.1-36(a) 3.1-36(b)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able			

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	to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on interview and record review, the facility failed to assist a resident with oral intake of meals for 1 of 1 resident reviewed with tube feeding. (Resident 17) Finding includes: Resident 17's clinical record was reviewed on 9/28/22 at 2:28 p.m. Diagnoses included, but were not limited to, dementia, dysphagia, history of stroke, moderate protein-calorie malnutrition, and attention to gastrostomy. A CNA (Certified Nursing Assistant) Assignment Sheet, dated 9/28/22, provided by the Corporate Nurse Consultant on 9/28/22 at 3:20 p.m., indicated the resident had a prescribed diet of regular food with pureed texture and nectar thick liquids and indicated the resident was to be "fed per staff." A quarterly Minimum Data Set (MDS) assessment, dated 7/21/22, indicated the resident had severe cognitive impairment, had no rejection of care, required extensive assistance of one staff	F 0693	**F693 Tube Feeding Mgmt/Restore Eating Skills S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Resident 17 is being assisted with oral intake of pleasure meals and has had no negative outcomes. **II. The facility will identify other residents that may potentially be affected by practice.** · Other residents with tube feed/oral intake have been reviewed and are being assisted with feeding as ordered. **III. The facility will put**	10/26/2022

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	for eating, had a feeding tube and mechanically altered diet, and received 26-50% of total calories through her feeding tube. The resident had a health care plan, revised 9/8/22, with an indicated problem of, resident receives a tube feeding with pureed diet. Goals included, but were not limited to, provide pureed diet and tube feeding and encourage compliance. A Registered Dietician Assessment, dated 8/5/22, indicated the resident had a current diet order for a regular diet, pureed texture, nectar-thick liquids and tube feeding. The average percent of oral intake was recorded as less than 50%. Interventions included, but were not limited to, continue to encourage oral food and fluid intake. Review of the resident's intakes for meals, indicated Nothing-By-Mouth (NPO) for the following meals: a. Breakfast on 9/28/22, 9/25/22, 9/23/22, 9/23/22, 9/16/22, 9/9/22, 8/31/22, 8/15/22, 8/14/22, and 8/8/22. b. Lunch on 9/25/22, 9/23/22, 8/31/22, 8/15/22, 8/14/22, and 8/8/22. c. Dinner on 9/4/22, 8/15,22, 8/14/22, and 8/13/22. During an interview on 9/29/22 at 9:32 a.m., CNA 3 indicated she did not feed Resident 17 by mouth every meal because she has her tube feedings also and sometimes pockets food in her mouth. When the resident's family fed her, she would enter the amount consumed for the resident's intake. When she entered NPO she was indicating the resident was not assisted to eat by her. During an interview on 9/29/22 at 9:36 a.m., the Assistant Director of Nursing (ADON) indicated		**into place the following systemic changes to ensure that the practice does not recur.** · QMA's and CNA's are being educated regarding assisting with and documenting accurate oral intake of pleasure foods while on a tube feed. **IV. The facility will monitor the corrective action by implementing the following measures.** · The DON or designees will review tube feed/oral food intake for those that are on a tube feed and ensure assistance and accuracy of documentation. This will be done daily for 4 weeks, weekly for 8 weeks, followed by quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 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:	

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	the resident should have been offered assistance with every meal. She had been educating CNA's on proper documentation. She indicated NPO should only be documented when a resident was unable or ordered to have nothing by mouth. Resident 17 was to be offered oral intake as well as tube feeding. A current facility policy, revised 3/2018, titled, "Activities of Daily Living (ADL), Supporting," provided by the Director of Nursing (DON) on 10/3/22 at 3:50 p.m., included, but was not limited to, the following: "Policy Statement Residents will be provided with care, treatment and services as appropriated to maintain or improve their ability to carry out activities of daily living (ADLs)... Policy Interpretation and Implementation...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with:...d. Dining (meals and snacks..." 3.1-37(a)		October 26, 2022 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation and interview, the facility	F 0698	**F698 Dialysis S/S D**	10/26/2022

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	155258	A. BUILDING 00 B. WING	10/04/2022

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	failed to develop and implement a method of communication with the dialysis provider for 2 of 2 residents reviewed with dialysis services (Resident 15 and Resident 33). Findings include: 1. Resident 15's clinical record was reviewed on 10/3/22 at 2:20 p.m. Current diagnoses included, but were not limited to, end stage renal disease, acquired absence of kidney, hypertension, dependence on renal dialysis, and diabetes mellitus. The resident had a physician's order dated 7/13/22 for dialysis at (Resident 15's dialysis provider's business name) at 11:00 a.m. on Monday, Wednesday, and Friday. The resident had a current care plan problem/need regarding the need for hemodialysis due to end stage renal disease. This care plan was originated 7/19/22. The clinical record for August and September 2022 indicated the resident left the facility to received dialysis 24 days as follows: 9/30/22, 9/28/22, 9/21/22, 9/19/22, 9/16/22, 9/14/22, 9/12/22, 9/9/22, 9/5/22, 9/2/22, 8/31/22, 8/29/22, 8/26/22, 8/24/22, 8/22/22, 8/19/22, 8/17/22, 8/15/22, 8/12/22, 8/10/22, 8/8/22, 8/5/22, 8/3/22, and 8/1/22. The clinical record lacked communication documents from the resident's dialysis provider for the 24 days listed above. During an interview on 10/3/22 at 3:25 p.m., the DON indicated the facility did not have any communication forms completed by Resident 15's dialysis provider during the months of August		**I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · The facility has contacted the dialysis center for Residents 15 and 33 to develop method of communication. **II. The facility will identify other residents that may potentially be affected by practice.** · Other residents receiving dialysis have been reviewed to ensure a method of communication has been developed. **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · Licensed nurses were educated on the correct forms of communication from the dialysis center as well as completion of the Pre and Post Dialysis forms. **IV. The facility will monitor the corrective action by implementing the following measures.**	

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	and September 2022. She indicated the facility would call the dialysis provider if they believed they needed additional information, but there was not a routine standard method of communication completed by the dialysis provider to ensure continuity of care. A current, undated, facility document titled "SNF Dialysis Services Agreement", which was provided by the DON on 10/3/22 at 3:57 p.m., indicated the contracted was established with the dialysis provider where Resident 15 received services. The contract included, but was not limited to the following: "D, Mutual Obligation 1. Collaboration of Care. Both partied shall ensure that there is documented evidence of collaboration of care and communication between the Nursing facility and ESRD Dialysis Unit." 2. Resident 33's clinical record was reviewed on 9/28/22 at 2:22 p.m. Current diagnoses included, but were not limited to, end stage renal disease and hyperkalemia (elevated potassium blood level). The resident had a physician's order dated 7/28/22 for the resident to receive dialysis on Monday, Wednesday and Friday. A current health care plan, dated 5/31/22 and revised 9/2/22, indicated the resident received hemodialysis due to end stage renal disease. The clinical record for August and September 2022, indicated the resident left the facility to received dialysis 20 times as follows: 8/3/22, 8/8/22, 8/10/22, 8/12/22, 8/17/22, 8/19/22, 8/22/22, 8/24/22, 8/29/22, 8/31/22, 9/2/22, 9/9/22, 9/12/22, 9/14/22, 9/19/22, 9/21/22, 9/23/22, 9/26/22, 9/28/22 and 9/30/22.		· The DON or designees will review residents on dialysis to ensure communication is occurring with the dialysis centers and that Pre and Post Dialysis forms are being completed. This will be done daily for 4 weeks, weekly for 8 weeks, followed by quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 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: October 26, 2022 The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.	

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The clinical record lacked communication documents from the resident's dialysis provider for the 19 of the 20 days listed above.

A review of a Nurse Practitioner progress note, dated 9/19/22, indicated the resident's dialysis provider reported the resident had severe anemia with a hemoglobin blood level of 5.9. The provider indicated the resident had a hemoglobin of 6.1 on Monday, 9/12/22 with a repeat hemoglobin of 5.9 on Wednesday 9/14/22. The facility had not been notified. The resident was sent to the emergency department for evaluation and treatment regarding his low blood hemoglobin levels.

During an interview on 10/03/22 at 3:26 p.m., the DON indicated the resident's dialysis provider had not sent information back with the resident. The staff completed a pre-assessment and sent the information with the resident. The provider had called before to inform staff the resident did not complete his dialysis cycle or had been sent to emergency room, but the facility doid not receive any information in writing regarding his treatments.

A current facility policy, dated 6/4/19, titled, "Hemodialysis Policy," provided by the DON on 10/3/22 at 4:09 p.m., included, but was not limited to, the following:

"Policy Statement
[Facility] will ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the individual resident's goals and preferences."

3.1-37(a)

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F 0777 SS=D Bldg. 00	483.50(b)(2)(i)(ii) Radiology/Diag Srvcs Ordered/Notify Results §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to obtain a physician ordered chest X-ray in a timely manner, resulting in a three-day delay in starting treatment for infection for 1 of 3 residents reviewed. (Resident 40) Finding includes: A clinical record review for Resident 40 was completed on 9/28/22 at 2:09 p.m. Diagnoses included, but were not limited to, shortness of breath, respiratory failure, and anxiety disorder. A nurse progress note, dated 8/5/22 at 5:11 p.m., indicated, "this nurse came into res [resident's] room, res has been sleeping all day, only eaten and drinking a little, res felt hot, temp [temperature] 100.9, o2 [oxygen saturation] was 78% on room air, lung sounds wheezy, NP [nurse practitioner] and son notified, N/O [new order] for UA [urinalysis] and chest X-ray." During an interview on 9/30/22 at 2:57 p.m., the	F 0777	**F777 Radiology/Diag Srvcs Ordered/Notify Results S/S D** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** · Resident 40 completed ordered treatment with no negative outcomes. **II. The facility will identify other residents that may potentially be affected by practice.** · Other residents with physician ordered diagnostic service in the last 7 days have been reviewed to ensure completion.	10/26/2022

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	Director of Nursing (DON) indicated the chest X-ray had been ordered on 8/5/22 at 3:31 p.m. and canceled on 8/5/22 at 3:31 p.m. She had not been able to determine why the X-ray had been canceled. A nurse practitioner (NP) progress note, dated 8/8/22, indicated the resident had been seen due to not feeling well with a cough, low pulse, low-grade fever and reports of some hypoxia (low oxygen level) over the weekend. The resident had been placed on supplemental oxygen. The chest X-ray that had been ordered on 8/5/22 had not been completed. A nursing progress note, dated 8/8/22 at 11:08 a.m., indicated the NP had been in to see Resident 40 and had given an order for STAT (immediate) chest x-ray, STAT lab work and breathing treatments. A NP progress note, dated 8/9/22, indicated the chest X-ray result included increased central congestion and increased infiltrates. (abnormal substance accumulated in tissues). The resident's chest x-ray was concerning for perihilar pneumonia. The resident was started on two oral antibiotics. A current facility policy, dated 6/6/19, titled, "Diagnostic Services," provided by the Corporate Nurse Consultant on 10/4/22 at 11:22 a.m., included, but was not limited to, the following: "Policy Statement It is the policy of CarDon & Associates, Inc. and its member Communities to provide each resident with the clinical laboratory, radiology, and other diagnostic services required to meet their needs and according to their physician's		**III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** · Licensed nurses are being educated regarding ensuring completion of physician ordered diagnostic services. **IV. The facility will monitor the corrective action by implementing the following measures.** · The DON or designees will review residents with physician ordered diagnostic services for completion. This will be done daily for 4 weeks, weekly for 8 weeks, followed by quarterly ongoing. The results of these reviews will be discussed at the monthly facility Quality Assessment and Performance Improvement meeting monthly for 6 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: October 26, 2022	

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	orders....Procedures:...8. Orders for diagnostic services will be promptly carried out as instructed by the physician's order." 3.1-49(j)(2)		The Administrator will be responsible for ensuring the facility is complying by date of compliance listed. The plan of correction is to serve as Countryside Manor Health and Living Community's credible allegation of compliance.	