

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2024
NAME OF PROVIDER OR SUPPLIER  Countryside Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE 762 N Dan Jones Rd Avon, IN 46123	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48226</b></p> <p>Based on observation, interview, and record review, the facility failed to accurately promote continuity of care and communication within the resident's care plan, to maintain resident safety, and safeguard against adverse events for 1 of 1 resident reviewed for care plans (Resident C).</p> <p>Findings include:</p> <p>During a phone interview on 1/18/24 at 3:20 p.m., the resident's responsible party indicated Resident C was not allowed to eat by mouth unless he was with a speech therapist. He was given a tray of ham and beans and a sandwich on Christmas eve. Resident C ate the meal. He called her and told her he had received a meal tray. She came into the facility and the nurse told her they had pulled food out of his mouth.</p> <p>On 1/18/24 at 3:40 p.m., Resident C was lying in bed with bedside items on the floor on top of a mat within reach. He indicated he was no longer seen by Speech Therapy (ST). He had a sign on the wall that identified he was to have no solid foods or regular liquids unless given by ST. He indicated had a sandwich a while back because he thought he had graduated, and they had brought him a tray. But he had not graduated from speech therapy.</p> <p>On 1/19/24 at 10:00 a.m., the medical record was reviewed. Diagnoses included but were not limited to, Food in respiratory tract part unspecified causing other injury, pneumonitis due to inhalation of food and vomit, malignant neoplasm of brain, chronic obstructive pulmonary disease (COPD) a group of diseases that cause airflow blockage and breathing-related problems, type 2 diabetes mellitus without complications (a disease that occurs when your blood glucose, also called blood sugar, is too high), and Epilepsy (a disorder of the brain characterized by repeated seizures).</p> <p>Physician orders included but were not limited to:</p> <p>Osmolite 1.5 bolus at 237 milliliters (mL) 5 times per day with 160 mL water flush each bolus.</p> <p>Occupational Therapy to treat 5 times a week from 8 weeks due to weakness/lack of coordination due to acute respiratory failure and history of brain tumor, treatment will include therapeutic exercises, Therapeutic activities, activities of daily living (ADL) skill training, manual modalities as needed, wheelchair management training, and group therapy as indicated.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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:  155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2024
NAME OF PROVIDER OR SUPPLIER  Countryside Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  762 N Dan Jones Rd Avon, IN 46123	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Two Cal 237 mL bolus with 200 mL water flushes per Gastric Tube as needed.</p> <p>Rezlidhia (olutasidenib) capsule 150 mg in gastric tube for cancer, twice a day.</p> <p>Diet order: nothing by mouth (NPO).</p> <p>A care plan, dated 12/22/2023, indicated resident had a nutritional risk related to primary diagnoses of food in respiratory tract, pneumonitis due to inhalation of food and vomit, malignant neoplasm of brain, COPD, type 2 diabetes mellitus, and dysphagia. Interventions included enteral feeding and bolus with (NPO) nothing by mouth diet, no food by mouth per order, honor known food preferences, offer substitution if consumes &lt;50% of meal, provide diet per MD Order: NPO, TwoCal bolus 4 times daily with 200 ml water flush each bolus.</p> <p>A care plan, dated 12/18/2023, indicated Resident C required chemotherapy. Approaches included: Avoid foods that resident complains about taste, do not chew or crush medicine, encourage oral intake of food and fluids, Fluids/feedings as ordered, keep fluids at bedside, offer available substitutes if resident has problems with the food being served, praise resident's attempts to complete meal, provide assistance for meals, provide ice chips. Problem Start Date: 01/18/2024 indicated the resident will put call light on and ask nursing staff specifically for solid foods. Resident was aware of current diet orders and restrictions. Resident would comply with dietary order, re-educate resident importance of following dietary orders.</p> <p>An admission Minimum Data Set (MDS), dated [DATE], indicated Resident C had dietary requirements of 51% or more with a gastric tube feeding.</p> <p>During an interview on 1/19/24 at 10:35 a.m. with the Director of Nurses (DON) and Executive Director (ED), the ED indicated the MDS nurse oversaw the care plans. The care plans were updated as needed or quarterly. Registered Nurse (RN) 5, did updates when a quarterly MDS review was completed. The interdisciplinary team (IDT), reviewed the care plan to ensure it was correct. After a resident was admitted during the admission MDS assessment all of the IDT team would review the MDS for accuracy. The DON and ED acknowledged the resident was given a regular meal on 12/24/23 and consumed it though he had a physician's diet order for nothing by mouth (NPO).</p> <p>During an interview on 1/19/24 at 10:45 a.m., RN 5 indicated when the resident was admitted , the floor nurse initiated a care plan, the next business day the MDS nurse reviewed the care plan and confirmed all areas and updates the care plan as needed. The care plan was then reviewed during quarterly assessment. RN 5 acknowledged the care plan for the resident was incorrect.</p> <p>The facility did not provide a policy for care plans.</p> <p>This citation relates to Complaint IN00425410.</p> <p>3.1-35(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2024
NAME OF PROVIDER OR SUPPLIER  Countryside Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  762 N Dan Jones Rd Avon, IN 46123	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>48226</p> <p>Based on observation, interview, and record review the facility failed to prevent a significant medication error by not following the manufacture administration guidelines for 1 of 2 residents reviewed for medication administration (Resident C).</p> <p>Findings include:</p> <p>On 1/18/24 at 3:20 p.m., phone interview with the resident's responsible party. She indicated the facility was not administering the resident's chemotherapy medication (Rezlidhia), correctly. She indicated she gave the nurse a copy of the special instructions as to how the medication was to be administered and it was on the medication bottle. The medication was an experimental medication and had very specific indications for administration.</p> <p>On 1/18/24 at 4:00 p.m., an interview with Licensed Practical Nurse (LPN) 3 indicated the resident just moved to the hall, and he was not sure what times his medications were to be given. He verified the administration record and indicated the Rezlidhia was to be given at 4 p.m. The next bolus feeding was due at 5:00 p.m. Review of the medication label identified the medication as Rezlidhia 150 milligrams (mg) one tablet two times per day (BID) on empty stomach.</p> <p>On 1/19/24 at 10:00 a.m., review of the medical record. Diagnosis included but were not limited to Food in respiratory tract causing other injury, Pneumonitis due to inhalation of food and vomit, Malignant neoplasm of brain, chronic obstructive pulmonary disease (COPD) a group of diseases that cause airflow blockage and breathing-related problems, Type 2 diabetes mellitus without complications (a disease that occurs when your blood glucose, also called blood sugar, is too high), and Epilepsy (a disorder of the brain characterized by repeated seizures).</p> <p>Physician Orders included but were not limited to:</p> <p>Osmolite 1.5 bolus at 237 milliliters (mL) 5 times a day with 160 mL water flush each bolus,</p> <p>Occupational Therapy to treat 5 times a week from 8 weeks due to weakness/lack of coordination due to acute respiratory failure and history of Brain tumor, treatment will include therapeutic exercises, Therapeutic activity, activity daily living skill training, wheelchair management training, and group therapy as indicated.</p> <p>Two Cal 237 mL bolus with 200 mL water flushes per Gastric Tube as needed.</p> <p>Rezlidhia (olutasidenib) capsule 150 mg by gastric tube for Cancer, Twice A Day.</p> <p>Diet order: NPO (nothing by mouth)</p> <p>The resident was discharged from the hospital on 12/15/23. The hospital discharge orders for the medication indicated it was to be administered two times a day (BID) at 8 am and 8 pm.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2024
NAME OF PROVIDER OR SUPPLIER  Countryside Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  762 N Dan Jones Rd Avon, IN 46123	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The manufacture guidelines for Rezlidhia indicated the following, .do not change your dose, or stop taking REZLIDHIA without talking to your healthcare provider, take REZLIDHIA 2 times a day (about 12 hours apart) around the same times each day, take REZLIDHIA on an empty stomach, at least 1 hour before or 2 hours after a meal</p> <p>Review of medication administration record (MAR), dated 12/15/23 to 1/11/24, indicated the medication was administered between 7:00 a.m. and 11:00 a.m. and between 7:00 p.m. and 10:00 p.m. The MAR, dated 1/15/24 to 1/19/24, indicated the medication was administered at 5:00 a.m. and 4:00 p.m. Documentation indicated the gastric bolus feedings were administered from 12/15/23 to 1/19/24 at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>On 1/19/24 at 10:35 a.m., interview with Director of Nurses (DON) and Executive Director (ED). The DON indicated the chemotherapy medication was administered through the gastric tube. She indicated she changed the medication administration times in January, after the resident's mother brought to her attention the times it was to be given. She acknowledged the prescription label on the bottle indicated the medication was to be administered on an empty stomach. The DON acknowledged they did not obtain an order to administer the medication 12 hours apart on an empty stomach.</p> <p>On 1/19/24 at 9:30 a.m., the DON provided an undated document titled, Med Pass Times, and indicated it was the policy currently being used by the facility. The policy indicated, .7:00 AM - 11:00 AM .7:00 PM - 10:00 PM . Medication orders outside of these times will be based on resident's physician orders</p> <p>On 1/19/24 at 11:54 A.M., the DON provided a document titled, LTC Facility's Pharmacy and Procedure Manual dated. 1/1/22, and indicated it was the policy currently being used by the facility. The policy indicated, .PROCEDURE . 4. Prior to administration of medication .4.1 .Facility staff should .4.1.1 .Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident as set forth in facility's medication administration schedule 5.8 .Follow manufacturer medication administration guidelines</p> <p>This citation relates to Complaint IN00425410.</p> <p>3.1-48(c)(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155792	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/19/2024
NAME OF PROVIDER OR SUPPLIER  Countryside Meadows		STREET ADDRESS, CITY, STATE, ZIP CODE  762 N Dan Jones Rd Avon, IN 46123	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0800</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.</p> <p>48226</p> <p>Based on observations, interview, and record review, the facility failed to implement a nothing by mouth (NPO) order for a resident with dietary restriction to ensure the resident was not given oral intake for 1 of 1 resident reviewed for gastric tube feedings (Resident C).</p> <p>Findings include:</p> <p>During an interview on 1/18/24 at 3:40 p.m., Resident C indicated he did not receive speech therapy services, but he had a sign on the wall that identified he was to have no solid foods or regular liquids unless given by speech therapist. The resident indicated he was given a sandwich a while back on a meal tray. He thought he had graduated and was cleared to eat since he was delivered a tray. He indicated he did not get choked when he ate the solid food, but the nurse removed the food from his mouth, and he had not had any solid foods since that happened. The resident indicated he was administered feedings through his gastric tube four times per day.</p> <p>On 1/19/24 at 11:39 interview with the Executive Director (ED) the ED indicated on 12/24/23 a certified nurse aide (CNA) obtained a tray for the resident from the dietary department. She did not provide a tray ticket and informed the staff she had lost the ticket. The CNA gave the resident the meal because he asked for a meal tray. The resident consumed some of the sandwich. A chest x-ray was obtained with no negative outcomes indicated. The ED indicated the kitchen staff was not to deliver a tray without a dietary ticket or approval from the nurse.</p> <p>During an interview on 1/18/24 at 5:17 p.m., Dietary Cook 4 indicated he did not serve a tray unless there was a dietary ticket on the tray. If a staff member requested a tray for a resident, they must provide a tray ticket to verify the dietary order. They did not send out trays for residents who were NPO, nothing by mouth status.</p> <p>The facility did not provide a dietary policy.</p> <p>This citation relates to Complaint IN00425410.</p> <p>3.1-20(a)</p>		