| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 165540 | A. BUILDING _____ B. WING _____ | C 08/20/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COUNTRYSIDE HEALTH CARE CENTER | 6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (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 |
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| F 000 | INITIAL COMMENTS<br><br>Correction date 9.11.19<br><br>The following deficiencies resulted from investigation of complaint #83298-C.<br><br>Complaint #83298-C was substantiated.<br><br>Investigation of complaint #83995-C did not result in deficiencies.<br><br>Complaint #83995-C was not substantiated.<br><br>See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C. | F 000 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, staff interview, pharmacy record review, pharmacy interview, physician office interview, and family interview, the facility failed to clarify and initiate an order for Parkinson's medication in a timely manner for 1 of 5 residents reviewed for professional standards (Resident #5). The facility reported a census of 38 residents.<br><br>Findings include:<br><br>The admission Minimum Data Set (MDS) assessment dated 4/9/19 documented diagnoses | F 658 | | |

| ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 9.13.19 |

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

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| F 658 | Continued From page 1<br>The care plan focus area initiated 4/2/19 identified a diagnosis of Parkinson's disease which placed the resident at risk for medical complications and declines in ability to complete ADL's with the progression of the disease process. The care plan directed staff to give medications as ordered by the physician and observe/document side effects and effectiveness.<br><br>The Progress Notes dated 4/22/19 at 11:00 a.m. documented a call made to the physician's office about the Neupro patch (a medication used to treat Parkinson's disease, also known as rigotine) and the physician's nurse stated it was discontinued due to costs. The facility informed the physician's nurse the family requested to start the patch and the nurse suggested a call to the insurance company before restarting.<br><br>The Pharmacy Facility Delivery Log dated 4/22/19 at 3:55 p.m. recorded the facility received 30 of the Neupro 8 mg (milligrams) per 24 hour patches and documented Private Pay.<br><br>The next Progress Notes entry related to the patch occurred on 4/25/19 at 5:06 p.m. Staff A, Registered Nurse (RN)/MDS Coordinator wrote she called pharmacy and the patch went through pharmacy with co-pay and family agreed to pay; pharmacy notified to send patch out that day. At 5:13 p.m., Staff A documented the patch delivered Monday (4/22/19) by pharmacy so medication reordered. At 6:20 p.m., Staff A documented care planning occurred for the resident and the patch reordered for her Parkinson's disease.<br><br>The Order Summary Report dated 4/30/19 and signed by the physician 5/1/19 included documentation of an active order for rotigotine 8 | F 658 | | |

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| F 658 | Continued From page 2<br>mg/24 hour patch one time a day for Parkinson's disease that originated on 4/25/19 with a start date of 426/19.<br><br>The April and May 2019 Mediation Administration Records (MARs) recorded the resident received rotigotine 8 mg/24 hour patch daily on the following days only: 4/26, 4/27, 4/28, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6.<br>On 4/3, 4/4, and 4/29 the MAR entries documented OT; which according to the legend indicated other, see nurses notes. The nurses notes for 4/29/19 contained no information related to administration of the patch.<br><br>On 8/14/19 at 4:00 p.m. a pharmacy representative stated on 4/22/19 the pharmacy sent the facility a box of 30 patches and since the facility would not have gone through them, they would not have sent more on 4/25/19. The pharmacy representative said the medication would have arrived at the facility no later than 4/23/19.<br><br>On 8/14/19 at 4:12 p.m., the physician's nurse stated on 4/22/19 the facility reported the son wanted the medication back and a fax sent to the facility's pharmacy for the Neupro patch.<br><br>On 8/14/19 at 4:41 p.m., Resident #5's family member stated on 4/20/19 they found out the resident not getting the Neupro medication and requested the medication be restarted. The family member commented they knew the medication delivered to the facility on 4/22/19 but the facility delayed starting the medication until 5 days later. The family member expressed concern their mother declined in progress of therapy after the discontinuation of the Parkinson's medication. | F 658 | | |

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| F 658 | Continued From page 3<br><br>On 8/15/19 at 10:15 a.m., Staff A recalled when the resident came off of skilled care, they then got the rotigotine patch ordered as the resident started having a decline in her Parkinson's disease. Staff A commented she recalled calling pharmacy and as she could not find the patch according to her documentation on 4/25/19 (Thursday). Staff A stated the pharmacy said they sent the patch out on Monday (4/22/19), so they resent them as she couldn't find them.<br><br>On 8/15/19 11:40 a.m., the DON said couldn't find the order signed by the physician 4/22/19 for the patch. The DON stated sometimes the doctor sends the pharmacy the order and then the facility did not know about the order. The DON stated the facility couldn't give the medication if they didn't have the written order. The DON provided a copy of the pharmacy delivery slip to show the patch for Resident #5 delivered 4/22/19. The DON acknowledged she would have expected staff to clarify 4/22/19 why they received the patch if no order. The DON stated Staff A entered the order into the computer as a written order (therefore the would be looking for an actual written script). | F 658 | | |
| F 684 SS=G | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This Requirement is not met as evidenced by: | F 684 | | |

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| F 684 | Continued From page 4<br>Based on clinical record review, staff interview, pharmacy record review, pharmacy interview, physician office interview, and family interview, the facility failed to initiate an order for Parkinson's medication upon admit, failed to cover the cost of the medication when the resident on skilled care, failed to notify the resident or resident representative the medication discontinued, failed to assess for adverse reactions to the discontinuation of the medication, failed to intervene when physical therapy first identified a regression of progress and emergence of Parkinson's symptoms, and failed to initiate a restorative maintenance program, for 1 of 5 residents reviewed for assessment and intervention (Resident #5). Resident #5 exhibited a regression in her third week of therapy ambulating half the distance as the week prior and stated she felt her Parkinson's symptoms had worsened. The facility reported a census of 38 residents.<br><br>Findings include:<br><br>The admission Minimum Data Set (MDS) assessment dated 4/9/19 identified a Brief Interview for Mental Status (BIMS) score of 14 without signs/symptoms of delirium. A score of 14 indicated intact cognition. The MDS revealed the resident required the extensive physical assistance of 2 persons for bed mobility, transfers, dressing, toileting, personal hygiene, and the resident did not walk in room or corridor during the assessment reference period. The MDS recorded the resident and direct care staff believed the resident capable of increased independence in at least some ADLs (Activities of Daily Living). The MDS documented diagnoses that included Parkinson's disease, difficulty walking, unsteadiness on feet, and weakness. | F 684 | | |

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| F 684 | Continued From page 5<br>The MDS recorded the resident started OT (Occupational Therapy) on 4/2/19 and PT (Physical Therapy) on 4/3/19.<br><br>The Discharge Return Not Anticipated (DRNA) MDS assessment dated 5/6/19 revealed the resident required extensive physical assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and the resident did not walk in room or corridor during the assessment reference period. The MDS recorded the resident ended OT and PT on 4/19/19.<br><br>The care plan focus area initiated 4/2/19 identified a diagnosis of Parkinson's disease which placed the resident at risk for medical complications and declines in ability to complete ADL's with the progression of the disease process. The care plan directed staff to give medications as ordered by the physician and observe/document side effects and effectiveness.<br><br>The hospital Clinical Summary dated 4/2/19 documented the resident with a hospital stay from 3/21/19 to 4/2/19. The discharge orders recorded no change made to the rotigotine medication, (a medication used to treat Parkinson's disease, also known as Neupro), 8 mg (milligrams) per 24 hour transdermal film, extended release patch; order to continue 1 patch topically once a day. The summary included documentation the resident last received a dose of rotigotine on 4/1/19. The Transfer Orders/Instructions included SNF (skilled) services necessary for continued skilled care needs.<br><br>The Progress Notes dated 4/3/19 at 5:03 p.m. documented telephone orders received for admit to skilled care for PT/OT/ST (Speech) therapies to evaluate and treat. | F 684 | | |

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| F 684 | Continued From page 6<br><br>The Progress Notes dated 4/4/19 at 10:16 a.m., written by Staff A, Registered Nurse (RN)/MDS Coordinator, documented a message left with the physician's nurse to see about ordering a substitute or discontinue the patch (Neupro); waiting for a return phone call.<br><br>On 4/4/19 at 2:20 p.m. the notes recorded a return phone call received with okay to discontinue the patch.<br><br>The Order Summary Report dated 4/10/19 and signed by the physician 4/16/19 lacked documentation of an active order for the rotigotine patch.<br><br>The Progress Notes dated 4/22/19 at 11:00 a.m. documented a call made to the physician's office about the Neupro patch and the physician's nurse stated it was discontinued due to costs. The facility informed the physician's nurse the family requested to start the patch and the nurse suggested a call to the insurance company before restarting.<br><br>The Pharmacy Facility Delivery Log dated 4/22/19 at 3:55 p.m. recorded the facility received 30 of the Neupro 8 mg/24 hour patches and documented Private Pay.<br><br>The next Progress Notes entry related to the patch occurred on 4/25/19 at 5:06 p.m. Staff A wrote she called pharmacy and the patch went through pharmacy with co-pay and family agreed to pay; pharmacy notified to send patch out that day. At 5:13 p.m., Staff A documented the patch delivered Monday (4/22/19) by pharmacy so medication reordered. At 6:20 p.m., Staff A documented care planning occurred for the | F 684 | | |

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| F 684 | Continued From page 7<br>resident and the patch reordered for her Parkinson's disease.<br><br>The Order Summary Report dated 4/30/19 and signed by the physician 5/1/19 included documentation of an active order for rotigotine 8 mg/24 hour patch one time a day for Parkinson's disease that originated on 4/25/19 with a start date of 426/19.<br><br>The April and May 2019 Medication Administration Records (MARs) recorded the resident received rotigotine 8 mg/24 hour patch daily on the following days only: 4/26, 4/27, 4/28, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6.<br>On 4/3, 4/4, and 4/29 the MAR entries documented OT; which according to the legend indicated other, see nurses notes. The nurses notes for 4/29/19 contained no information related to administration of the patch.<br><br>The Progress Notes dated 4/29/19 at 7:12 p.m. recorded the resident approved to move to an acute assisted living facility.<br>On 5/6/19 at 11:23 a.m. the notes recorded the resident transferred out of the facility to the acute assisted living facility transported by family.<br><br>Therapy Documentation<br>The Physical Therapy Plan of Care (POC) dated 4/3/19 documented therapy necessary for strengthening, conditioning, and balance; without therapy patient at risk for loss of function/increase dependence on caregivers.<br><br>The Tinetti Assessment Tool is a simple, easily administered test that measures a resident's gait and balance. The test is scored on the resident's ability to perform specific tasks. It uses a 3-point ordinal scale of 0, 1 and 2. Gait is scored over 12 | F 684 | | |

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| F 684 | Continued From page 8<br>and balance is scored over 16 totaling 28. The lower the score on the Tinetti test, the higher the risk of falling.<br>The Rehab Services Tinetti Assessment Tool- 4 week form documented results of combined balance and gait tests. The scores were as follows: 4/3/19 = 7/28; 4/10/19 = 9/28; 4/17/19 = 5/28.<br>The results of the third week revealed a regression in gait and balance lower than when the resident started therapy on 4/3/19 indicating a high fall risk.<br><br>The PT Daily Treatment Note dated 4/17/19 recorded the following informational note: Co-treat/supervisory visit with PTA (Physical Therapist Assistant); notes reviewed and Plan of Care discussed. Tinetti reassessed with score markedly decreased. Balance assessment -3 to 3/16 and -1 to 2/12 on Gait assessment for 5/28 (8/28 modified) for high fall risk with front wheeled walker. Patient regressed from minimum to maximum assist with sit to stands. The resident walked 5 feet (30 feet last week) with front wheeled walker with contact guard assist (contact with patient due to unsteadiness). Patient even commented that she felt her Parkinson's had really worsened. PTA and COTA (Certified Occupational Therapist Assistant) stated they noted decline since Monday (4/15/19). PTA to continue as per POC with therapeutic exercise, gait, neuro re-education, and the activity progressing as able.<br><br>The PT Therapist Progress & Discharge Summary dated 4/19/19 recorded:<br>Analysis of Functional Outcome/Clinical Impression -<br>Discharged secondary to insurance stopped covering skilled days. The Tinetti was net +2 to | F 684 | | |

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| F 684 | Continued From page 9<br>9/28 (13/28 Modified) for high fall risk. However inconsistent with transfers varying minimum to maximum assist with sit to stands. Ambulation tolerance also varied 20 to 60 feet with front wheeled walker with contact guard assist.<br>Discharge Plans & Instructions -<br>LTC (Long Term Care); recommend RNP (Restorative Nursing Program) by facility once able to integrate and staff. The resident would be a candidate for walk to dines, walking less than or equal to 80 feet with front wheeled walker, standing frame, seated therapeutic exercises, and NuStep (recumbent stepper).<br><br>The clinical record lacked documentation the Restorative Nursing Program initiated by the facility as recommended by the therapy department.<br><br>Interviews<br>On 8/14/19 at 4:00 p.m. a pharmacy representative reported the documentation on their end showed issues with insurance covering the Neupro patch to begin with (4/3/19) as the medication was not in their formulary. The pharmacy representative stated they sent the physician a PA (Preauthorization) form and thought it would be in the doctor hands after that as far as documentation and commented they send the requests via electronic software. The pharmacy representative stated on 4/22/19 the pharmacy sent the facility a box of 30 patches and since the facility would not have gone through them, they would not have sent more on 4/25/19. The pharmacy representative said the medication would have arrived at the facility no later than 4/23/19.<br><br>On 8/14/19 at 4:12 p.m., the physician's nurse stated she showed no communication from the | F 684 | | |

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| F 684 | Continued From page 10<br>facility's pharmacy regarding a PA form around 4/3/19. The physician's nurse reported Staff A called the physician's office on 4/4/19. The physician's nurse reported Staff A said the resident used the patch at home but not at the facility and Staff A wanted to know if there was a substitute due to the high cost or if they should discontinue the medication if no other substitutes. The physician's nurse stated the physician responded let's just discontinue the patch. The physician's nurse stated on 4/22/19 the facility reported the son wanted the medication back and a fax sent to the facility's pharmacy for the Neupro patch.<br><br>On 8/14/19 at 4:41 p.m., Resident #5's family member reported they spoke with the physician's nurse who had cared for the resident for 14 years. The family member stated they were told by the physician's nurse the facility called to inform them the family said the Neupro medication too expensive, however, the family member denied that stating they never complained about the high cost. The family member expressed concerns the medication was discontinued without notifying them as they were willing to pay out of pocket for the medication if needed. The family member reported they were concerned about their mother declining in physical therapy at that time so they checked with the facility to ensure the resident receiving the Neupro medication. The family member stated on 4/20/19 they found out the resident not getting the medication and requested the medication be restarted. The family member commented they knew the medication delivered to the facility on 4/22/19 but the facility delayed starting the medication until 5 days later. The family member expressed concern their mother declined in progress of therapy after the discontinuation of | F 684 | | |

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| F 684 | Continued From page 11<br>the Parkinson's medication.<br><br>On 8/15/19 at 10:15 a.m., Staff A recalled Resident #5 admitted to the facility under skilled care and the Neupro (rotigotine) patch expensive as was some $700 to $800. Staff A reported she was told to try to get a substitute for the medication; Staff A responded she thought the former DON asked her to call the doctor to ask as the facility was responsible to cover the cost. Staff A reported when the resident came off of skilled care, they then got the rotigotine patch ordered as the resident started having a decline in her Parkinson's disease. Staff A commented she recalled calling pharmacy as she could not find the patch according to her documentation on 4/25/19 (Thursday). Staff A stated the pharmacy said they sent the patch out on Monday (4/22/19), so they resent them as she couldn't find them. Staff A clarified the high cost as the reason for the patch discontination when the resident initially entered the facility. Staff A responded she didn't remember asking the resident or the family to pay for it. Staff A stated she talked to the resident but did not recall asking her to pay for it. Staff A responded normally she would notify the family or resident about medication changes and typically documented the notification in the progress notes. Staff A did not recall any fax documentation pertaining to the authorization of the patch; she thought communication was just with phone calls made back and forth with pharmacy and the physician's office. Staff A confirmed the facility would have been responsible for the cost of the rotigotine patch while the resident on skilled care, even with a Medicare replacement plan as the payor source. Staff A responded restorative documentation in the computer, therapy writes recommendations and then goes into PCC (electronic chart). | F 684 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 165540 | A. BUILDING _____ B. WING _____ | C 08/20/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE HEALTH CARE CENTER | 6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106 |

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|---|---|---|---|---|
| F 684 | Continued From page 12<br><br>On 8/15/19 at 10:40 a.m., the Director of Nursing (DON) responded if a resident received Medicare or a Medicare replacement plan, the facility is responsible for the cost of resident medications. The DON commented the facility completes a screen for potential new admissions and reviews their medications for potential high costs. The DON confirmed the facility would have been responsible for the cost of Resident #5's medication at the time of admit, including the rotigotine patch.<br><br>On 8/15/19 at 11:00 a.m., the DON reported she was unable to find restorative program notes for Resident #5.<br><br>On 8/15/19 11:40 a.m., the DON said couldn't find the order signed by the physician 4/22/19 for the patch. The DON stated sometimes the doctor sends the pharmacy the order and then facility did not know about the order. The DON stated the facility couldn't give the medication if they didn't have the written order. The DON provided a copy of the pharmacy delivery slip to show the patch for Resident #5 delivered 4/22/19. The DON acknowledged she would have expected staff to clarify 4/22/19 why they received the patch if no order. The DON stated Staff A entered the order into the computer as a written order (therefore the would be looking for an actual written script).<br><br>On 8/19/19 at 12:45 p.m. a follow-up phone call placed to the physician's office. The physician's triage nurse reported the resident transferred her care from them on 6/21/19. The physician's triage nurse stated they had documentation to show the daughter was upset the medication had been stopped. The physician's triage nurse identified the resident her own POA (Power of | F 684 | | |

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|---|---|---|---|---|
| F 684 | Continued From page 13<br>Attorney) and reported loss of function of her right leg at that time. The physician's triage nurse stated the facility called 4/4/19 to report the medication cost too high and asked for a substitute. The physician's triage nurse stated the physician said there were no other substitutes so if the medication too high a cost they would just discontinue it. The physician's triage nurse stated their record showed the resident's abilities declined and had they not got a call from the facility about the high cost then the resident would have remained on the medication. | F 684 | | |

2567

F 658: Services Provided to Meet Professional Standards

The services provided by facility as outlined in the comprehensive care plan does meet professional standards of care.

The facility will assure all new medication orders must be initiated without delay according to MD orders. Any orders requiring clarification must receive that clarification so as not to delay initiation of the order. All delays in therapy must be reported to the MD and family, stating the reason for delay and documented in the medical record.

a) Resident #5 was identified to be affected by deficient practice. However, all residents have the potential to be affected.
b) An audit was created to monitor new medication orders, and initiation of medication administration.
c) Licensed Nursing/Nurse Managers have been educated on completion of the audit, the order process, and initiation medication administration. Also educated on seeking clarification for applicable situations, and notification process for delays in care.
d) DON/Designee will perform daily audits of these systems and IDT to review for on-going basis with results forwarded to QA&A Committee for further review.
e) Responsible Party: Director of Nursing/Designee
f) Compliance Date: 9/11/2019

F 684: Quality of Care

The facility does ensure that residents do receive treatment and care in accordance with professional standards of practice based on each resident's comprehensive assessments.

The facility will assure all new medication orders must be initiated without delay according to MD orders. New/changes to medications will be monitored for negative outcomes, and notification made to MD and family for appropriate treatment decisions to be made. Therapy will report declines to IDT daily, Nursing to notify MD and Family of declines. Facility will initiate restorative nursing programs as recommended by the therapy department.

a) Resident #5 was identified to be affected by deficient practice. However, all residents have the potential to be affected.
b) An audit was created to monitor new medication orders, and initiation of medication administration, Therapy Recommendations, Restorative Nursing Audit, and clarification of orders. Residents discharged from skilled therapy and w/ ADL declines were audited to ensure that therapy restorative recommendations were initiated. The agendas to the Morning Clinical Meeting and Medicare Meeting were amended to specifically include therapy discharges and restorative nursing recommendations.
c) Licensed Nursing/Nurse Managers have been educated on new medication initiation, order process, assessing declines and adverse reactions for medication changes, and notification process for MD and family. Therapy educated to report declines to IDT. Nursing educated to initiate restorative program as recommended by therapy.
d) DON/Designee will perform daily audits of these systems and IDT to review for on-going basis with results forwarded to QA&A Committee for further review.
e) Responsible Party: Director of Nursing/Designee
f) Compliance Date: 9/11/2019