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 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 000	INITIAL COMMENTS Correction Date: 5/12/2023 + 5/26/2023 An investigation of Complaints #112410-C, #112548-C and 112767-C was completed from 4/27/23 through 5/11/23 and resulted in the following deficiencies. Complaints: #112410-C, #112548-C, & #112767-C were all: Substantiated. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure residents were treated in a dignified manner for 3 of 5 residents reviewed (Resident #5, #11, and #10). The facility reported a census of 54 residents.	F 600		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] Jackie Loghry Pirner

TITLE: Administrator

(X6) DATE: 6/2/2023

05/25/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1	F 600		

Findings include:

1) According to the Minimum Data Set (MDS) dated 4/4/23, Resident #5 had a Brief Interview for Mental Status (BIMS) score of 5 (severe cognitive deficits). She required limited assistance with the help of one staff for eating and diagnosis that included cancer, malignant neoplasm of cerebellum.

A care plan dated 4/18/23 indicated that Resident #5 was at nutritional risk related to her diagnosis and weight loss was unavoidable. Staff were directed to encourage food and fluids.

On 5/4/23 at 7:32 AM, Resident #5 was in a wheel chair and pushed up to the table for breakfast in the dining room. Her eyes were closed. At 7:52 AM and at 8:01 AM she was in the same position with her eyes closed and mouth open. No food or drink had been offered. At 8:08 AM Certified Nurse's Aide (CNA) Staff C asked her if she was going to eat any breakfast and took the cellophane off a cup of juice, but she did not put it to the resident's mouth. Resident #5 did not respond. Staff C said that she would be right back and went to help another resident. At 8:18 AM staff placed a plate of food in front of her and Certified Medication Aide (CMA) Staff D put some eggs in her mouth. Staff D said loudly; "you need to swallow". The resident's eyes were closed, she did not chew or swallow the eggs. Staff D gave her a small sip of water and said; "do you want to spit it out? Swallow." She gave her another drink but the resident was not chewing. At 8:21 Staff D said; "she's done" The resident did not open her eyes. At 8:22 Staff D said "if you're not going to swallow, we can't give you more." At 8:23 AM

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	165540	A. BUILDING ______ B. WING ______	C 05/11/2023

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COUNTRYSIDE HEALTH CARE CENTER	6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

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F 600	Continued From page 2 Staff D moved the resident out of the dining room and back to her room. 2) In an observation on 5/3/23 at 6:57 AM, 7 residents in wheel chairs were sitting around the nurse's station. On 5/4/23 at 7:15 AM, 10 residents were sitting in wheel chairs in an open area around the nurses' station. Many of them had their eyes closed. On 5/10/23 at 6:26 AM Resident #11 was in a wheel chair and Staff C pushed him out by the nurse's station where 4 other residents were sitting, facing the nurses. A CMA took his blood pressure an announced the results. At 6:32 AM Resident #13 (MDS dated 3/22/23 showed a BIMS of 3, severe cognitive deficits) was pushed in a wheel chair to the area. In a low monotone voice she repeated "help me, help me". As she continued to mumble, her eyes were closed, head hung down, and her dentures slipped slightly out of her mouth. At 6:39 a CMA acknowledged that the dentures were falling out and moved the resident to another side of the room. At 6:45 AM, CNA Staff C took the teeth out of the resident's mouth in front of other residents. 3) On 5/10/23 at 6:23 AM Resident #11 and Resident #10 were observed in their wheel chairs sitting near the nurse's station. At 7:15 AM and 7:35 AM and at 8:00 AM they were in the same position and 8 other residents had been added to the group. According to the MDS dated 2/9/23, Resident #10 had a BIMS score of 14. On 5/9/23 at 1:09 PM the resident said that he didn't care for the way that the residents were lined up before meals and said that it was degrading.	F 600		

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	165540	A. BUILDING ______ B. WING ______	C 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 600	Continued From page 3 On 5/10/23 at 7:12 PM the Director of Nursing (DON) said that the staff would usually ask the resident if it would be okay to have them wheeled out to wait for breakfast. A facility policy titled: Respect and Dignity: reviewed in October of 2022, the facility staff and management would maximize to the extent possible the characteristics of the facility that reflect a personalized, homelike setting.	F 600		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review the facility failed to accurately assess and provide timely intervention for 2 of 3 residents reviewed (Resident #3 and #4). Staff failed to contact the physician when Resident #3 had low urine output and failed to complete all vital signs when Resident #4 had a change in status. The facility reported a census of 54 residents. Findings include: 1) According to the Minimum Data Set (MDS) dated 4/29/23 Resident #3 had a Brief Interview	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 05/11/2023

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 4	F 684		

for Mental Status (BIMS) score of 14 (intact cognitive ability). The resident required extensive assistance with the help of 2 staff for bed mobility, transfers, dressing, and toilet use. The resident had diagnoses of acute osteomyelitis, urine retention, pressure ulcers, sarcoidosis (inflammatory disease), and an indwelling urinary catheter. The resident did not have shortness of breath upon admission on 4/24/23.

The care plan updated on 4/24/23 showed that Resident #3 had the potential for infection related to diagnosis of urinary retention. Staff were directed to assess, record, and report to the physician of signs and symptoms of urinary tract infection such as no urine output for 8 hours, cloudy or foul-smelling urine, small amounts of voiding, and bladder distention.

On 5/2/23 at 3:58 PM, Resident #3 was in a wheel chair in her room. She was slumped over, and an unidentified staff member was crouched down next to her with cup of pills and a glass of water. The staff member was trying to rouse the resident enough to take the medications and sip through a straw. The resident did not open her eyes and took a couple of drinks.

A Nursing Note dated 5/2/23 at 11:16 PM showed that Resident #3 was having a difficult time opening her eyes and was not following commands. Staff then took her vital signs and found that she had a blood pressure of 86/40. She was cold to the touch and the doctor was called and she was sent to the hospital.

A hospital report dated 5/3/23 at 2:34 PM indicated that the resident presented with the following diagnosis: acute encephalopathy, acute

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 05/11/2023

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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
F 684	Continued From page 5	F 684		

kidney injury with oliguria (low urine output) and hypernatremia (high sodium level, likely secondary to dehydration). Oliguria in adults is usually less than 500 milliliters (ml) in a 24 hour period. Retrieved on 5/10/23 from: Urine Output (cdc.gov)
A nursing note on 5/7/23 at 4:06 PM showed that the resident had passed away at the hospital.

A review of the clinical record documentation of the daily urine output from the catheter was as follows:
a. On 4/26/23, 250 ml
b. On 4/27/23, 250 ml
c. On 4/29/23, 400 ml
d. On 4/30/23, 200 ml
e. On 5/1/23, 350 ml
f. On 5/2/23, 0 ml

The chart lacked documentation that the physician had been contacted about the low urine output.

On 5/3/23 at 2:07 Certified Nurse Aide (CNA) Staff A said that she had noticed that Resident #3 had a distended belly in the days leading up to the hospitalization.

On 5/8/23 at 3:41 PM CNA Staff J said that she had emptied the catheter bag for Resident #3 a couple of times and she had very little urine and it was cloudy. She said she reported this to nursing staff.

On 5/8/23 at 3:20 PM CNA Staff H said that she would report to nursing if urine in the catheter bag had a dark color or if it wasn't draining. If the urine output was less than 50 cc she said she would report to nursing.

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 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 684	Continued From page 6	F 684		

On 5/9/23 at 6:42 AM, RN Staff F said that she thought that a urine output of less than 30 cc an hour would be concerning. She hadn't had any staff come and tell her recently about low output concerns.

According to the "Order" tab in the electronic chart, Resident #3 had the following order for a medication to regulate hypotension (low blood pressure): Dated 4/28/23 at 3:52 PM, Midodrine 5 milligrams (mg) Give 3 tablets before meals for hypotension (low blood pressure). Give only if systolic (top BP number) was less than 90.

According to the order, the Blood Pressure (BP) was to be taken three times a day before administration of the medication. The electronic chart showed that from 4/28/23 - 5/1/23 the BP had only been taken once a day.

The Medication Administration Record (MAR) showed the following administration of Midodrine;

a. May 1st Midodrine 5 mg 3 tabs given at 6:00 AM and 11:00 AM and not at 4:00 PM because the BP was out of the parameters.
b. May 2nd given at 6:00 AM and 11:00 AM and not at 4:00 PM because the BP was out of parameters.

On 5/9/23 at 10:37 AM LPN Staff G said that she had been charting at the end of her shift when the RN that was coming on told her that the resident was non-responsive with a low blood pressure. She said she held the Midodrine on 5/2/23 at 4:00 PM because the BP had been above 90. She said she charted that in the MAR.

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 05/11/2023

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 7 F 684

On 5/9/23 at 12:10 PM, a physician for Resident #3 said that the low blood pressure many have been caused by an infection and she wasn't sure if a dose of Midodrine before she went to the emergency room would have made a difference in the outcome. She did not have any communication from the facility regarding low urine output. The doctor said that output numbers were somewhat concerning, and certainly an output of 0 would have caused her to have her sent in for an evaluation. She said that documenting doesn't make a difference if the staff didn't follow up with the doctor. She would have instructed staff to push fluids, but it was difficult to say what else she may have ordered if she had known about the low output.

2) According to the MDS dated 4/8/23 Resident #4 had a BIMS score of 3 (severe cognitive deficits). The resident was admitted on 3/16/23 with diagnoses that included fracture of the right shoulder, anemia, seizure disorder, blindness in the right eye, and respiratory failure. The resident required extensive assistance with the help of one staff for bed mobility, transfers, dressing and toilet use. Limited assistance with help of one staff for eating. The resident was not on a trial toilet use or scheduled bladder training, occasionally incontinent of urine, and frequently incontinent of bowel.

The Care Plan updated on 3/28/23 showed that Resident #4 was at nutritional risk related to respiratory failure and anemia. The resident had edema and was at risk for shortness of breath. Staff were directed to encourage the resident to elevate her feet and legs daily and to administer medications as ordered. Staff were to notify the physician promptly of breathing changes, chest

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 05/11/2023

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COUNTRYSIDE HEALTH CARE CENTER	6120 MORNINGSIDE AVENUE SIOUX CITY, IA 51106

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F 684	Continued From page 8	F 684		

pain, signs and symptoms of dehydration, and concentrated urine. Monitor and document signs and symptoms of long term effects of renal failure.

A nursing note 4/24/2023 at 4:40 PM showed that Resident #4 was sitting in a recliner in the common area by nurses station and the CNA attempted to take her to the bathroom, but the resident was not responding. They tried to sit her up and wake her when she slumped over in chair. They then tested her oxygen level and it was 85% on room air. They applied supplemental oxygen and it improved but the resident was still lethargic. She was transferred to the hospital.

A hospital report dated 4/25/23 at 3:37 PM showed diagnoses of acute respiratory distress, sepsis (infection in the bloodstream), and severe lactic acidosis (acid in the blood stream).

Nursing note on 4/26/23 at 9:29 AM showed that the resident was readmitted to the facility on Hospice comfort measures only and she passed away at 12:07 on 4/26/23.

The following is a list of vitals that had been taken leading up to the hospitalization:

a. 4/23 at 9:00 AM BP 144/88 and Pulse (P) 70 Beats Per Minute (BPM), no Oxygen (O) Respirations (R) or Temperature (T).
b. 4/23 at 5:16 PM BP 136/80 and P 66 no O, R or T
c. 4/24 vitals at 7:42 AM 130/78 P 58 no O, R or T
d. On 4/24/23 at 4:40 PM a Nurse found the resident slumped over in her chair, 911 called with oxygen level of 85%.

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 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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

F 684 Continued From page 9 F 684

On 5/3/23 at 10:28 AM An Emergency Medical Technician (EMT) said that he was the lead provider on 4/24/23 when they got the call to come to the facility for Resident #4. They found her unresponsive with very slight response to pain stimuli. The staff told them that she had a change in condition the previous night and wasn't getting out of bed. The EMT staff provided airway management while she was in the ambulance and she was intubated (inserted tube into the trachea for ventilation) at the hospital.

On 5/3/23 at 4:12 PM, Registered Nurse (RN) Staff Q said that when she came on shift at 2:00 PM on 4/24/23, Resident #4 was in the recliner near the nurses' station and appeared to be resting which was not unusual. The Aide decided to offer toilet use and tried to wake the resident but she wasn't responding. She said that in shift report, the staff had mentioned that she hadn't eaten her lunch and kept dosing off and that was not normal for her. The CNA mentioned that the resident had been lethargic the day before.

On 5/3/23 at 4:14 PM Certified Medication Aide (CMA) Staff R was in the recliner out by the nurse station when she came on shift at 2:00. When the resident would not arouse, they took her to the bedroom and laid her down. She did not remember if someone took vitals at that time or what her last vitals were. The day before around bedtime she had been more lethargic. She notified the nurse and she called the doctor.

On 5/3/23 at 2:07 CNA Staff A said that she had worked with the resident a couple of times and had noticed in the days leading up to the hospitalization that the resident was leaning more. About 1 week before the hospitalization,

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 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 684	Continued From page 10 she noticed the resident was more lethargic and she told the nurses. She did not know if there was a follow up assessment completed. On 5/4/23 at 11:46 AM the doctor's office said that the cause of death was chronic pulmonary disease. On 5/10/23 at 7:12 PM the DON said that she was not aware that Resident #4 had a change in condition the day before she went to the hospital. She said she would expect that staff take all the vitals if a resident had a change, not just the BP and pulse. On 5/10/23 at 7:12 PM the DON said that she could not say for sure when a low urine output should be reported because it would depend on the resident and their diagnosis and if they had some leaking or history of low output. In a healthy resident 30cc an hour was the standard. According to facility policy titled: Output Measuring and Recording last reviewed in May of 2022 the purpose of the policy is to accurately determine the amount of urine a resident excretes in a 24 hour period and staff were directed to report information in accordance with professional standards. A facility policy titled: Comprehensive Assessments last revised in August of 2022 indicated that the residents would receive an accurate assessment that is reflective of the resident's status at the time of assessment.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
F 689	Continued From page 11	F 689		

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review the facility failed to follow interventions for fall risk for 1 of 3 residents reviewed for falls (Residents #7) and failed to implement neurological assessments after a fall for 1 of 3 residents reviewed for falls (Resident #11). The facility reported a census of 54 residents.

Findings include:

1) According to the Minimum Data Set (MDS) dated 3/20/23 Resident #7 had a Brief Interview for Mental Status (BIMS) score of 14 (intact cognitive ability). He required extensive assistance with the help of one staff for bed mobility and dressing, extensive assistance with the help of two staff for transfers and toilet use. Resident #7 had diagnoses that included hip fracture, Parkinson's Disease, muscle wasting, and lack of coordination.

The Care Plan revised on 11/8/22 showed that he was at risk for falls related to impulsiveness, poor balance, and Parkinson's Disease.
An incident report dated 4/14/23 at 5:36 PM showed that Resident #7 was found face down in his room with the recliner on top of him. The remote control for the electric recliner was in his hand. A root cause analysis included an

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 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12 intervention to keep the remote control out of reach. On 5/8/23 at 3:40 PM Resident #7 was in his recliner and the remote was in his lap on his right side. On 5/9/23 at 10:20 AM Resident #7 was in his recliner with the foot rest up. The call light was hooked to the chair and the chair remote was in his lap on the right side. During an interview on 5/9/23 at 11:50 AM Licensed Practical Nurse (LPN) Staff K stated she found Resident #7 after his fall from recliner. He was face down on the floor and the chair was on top of him. She said that he had gotten the remote and had moved the chair too high in the air and it tipped over onto him. This was the only fall she was aware of for him and the intervention was to keep the remote from him. She said that the family agreed to this plan. 2) According to the MDS dated 4/7/23 Resident #11 had a BIMS score of 11 (moderate cognitive deficits). The resident required extensive assistance with the help of 1 staff for toilet use, dressing, and hygiene. According to a Nursing Note dated 1/5/23 at 7:20 PM Resident #11 was found on the floor after an unwitnessed fall, and his head was bleeding. Staff wrapped his head and took an initial set of vital signs. The note indicated that neurological checks had been completed, and the ambulance was called. The chart lacked documentation that the neurological checks had been completed per	F 689		

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 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 13 policy. On 5/10/23 at 7:10 PM the DON acknowledged that there was no documentation that the neurological assessments had been completed. A facility policy titled: Falls and Fall Management last reviewed in October of 2022 showed that staff would identify interventions related to residents' specific risks and causes to try to prevent the resident from having further falls.	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		

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F 725	Continued From page 14 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure that residents were able to reach their call lights and that the call lights were answered in a timely fashion for 3 of 5 residents reviewed for call lights (Resident #6, #10 & #12). The facility reported a census of 54 residents. Findings include: 1) According to the MDS dated 5/2/23 Resident #6 had a BIMS score of 13 (cognitively intact). The resident required extensive assistance with the help of two staff for bed mobility, transfers, toilet use, and dressing. Diagnoses included diabetes mellitus, traumatic brain injury, gastritis with bleeding, and acquired absence of the right leg below the knee. The Care Plan dated 5/1/23 indicated that the resident was incontinent and staff were directed to assist with toilet use/ bed pan or commode as needed and he required 2 staff assistance for transfers. The resident had self-care deficits, impaired balance during transitions required assistance with walking. According to an incident report dated 5/2/23 at 6:36 PM the resident was found lying on the floor and was complaining of pain to his back and stated that he had hit his head. Staff reported that there were no noticeable injuries and emergency services had been called.	F 725		

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F 725	Continued From page 15	F 725		

On 5/10/23 at 8:03 AM a family member for Resident #6 said that he had been on the toilet and pushed the call light many times. When no one came, and his leg started to cramp, he decided to try to get himself back to the bed and that was when he fell.

On 5/10/23 at 7:12 PM the Director of Nursing DON said that Resident #6 did tell her that he had the call light on when he was on the toilet and had been waiting for 15-20 minutes. He told her that he was banging on the walls to get attention and then he tried to walk back to his bed by himself.

2) According to the MDS dated 2/9/23, Resident #10 had a BIMS score of 14 (cognitively intact). On 5/9/23 at 1:09 PM the resident said that there had been several times when he needed something and he couldn't reach the call light while he was in bed. He said that when that happened, he had to holler out to get someone's attention. He said they didn't like it when he hollered but that is the only way to get their attention if he couldn't find the light.

3) An MDS dated 5/4/23 showed that Resident #12 had a BIMS score of 8 (moderate cognitive deficits). He required limited assistance with the help of one staff for transfers, locomotion, dressing, and toilet use. The Care Plan dated 4/19/23 showed that he was at risk for falls related to muscle wasting, atrophy, and osteoporosis with fractures. Staff were directed to ensure that the call light was within reach and to encourage the resident to use the call light.

In an observation on 5/10/23 at 6:13 AM Resident #12 was in bed and the call light is on the floor out of his reach.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 725	Continued From page 16 On 5/10/23 at 7:10 PM the DON the said that Resident #12 could get up from the bed himself and he probably had taken the call light off the bed. A facility policy titled: Answering Call Lights, last reviewed in May of 2022 showed that when a resident was in bed or confined to a chair, staff were to ensure that the call lights was within easy reach of the resident and to answer the call light in a timely manner.	F 725		

Countryside Health Care Center

Plan of Correction

Recertification/Focused Infection Control/Complaint Survey Conducted April 27-May 11, 2023

Plan and/or execution of this plan of correction does not constitute admission or agreement by this provider of the truth of deficiencies. The plan of correction is prepared and executed solely because it is required in accordance with State and Federal Law.

F600 Free from Abuse and Neglect

The facility does ensure that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.

A. Resident #5 no longer resides at the facility. Resident #11's blood pressure will be taken in his room and not at the nurse's station. Resident #10 is asked when he leaves his room where he would like to sit and if he does not want to sit by the nurse's station he can move independently or ask staff for assistance.
B. Residents residing in the facility have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Staff have been educated by DON/Designee on resident rights. Residents are interviewed during Hall Hero rounds Monday through Friday mornings to ensure Resident Rights are being met and addressed and discussed in Morning Meeting.
D. The DON/Designee will audit dignity/resident rights daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: ADM/DON/Designee

Compliance Date: 5/26/2023

F684 Quality of Care

The facility does ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices.

A. Residents #3 and #4 no longer reside at the facility.
B. Residents experiencing a change in condition residing in the facility have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Nursing staff were educated by the DON/Designee regarding the need for timely treatment and care for residents experiencing changes in condition and/or incident/accidents.
D. The DON/Designee will review the 24-hour report to identify any resident change in condition daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 5/12/2023

F689 Free of Accident Hazards/Supervision/Devices

The facility does ensure that the residents environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

A. Resident #7’s chair remote is out of reach and has been placed behind the chair with Velcro. Resident #11’s neurological checks were completed.
B. Residents experiencing a change in condition residing in the facility have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Nursing staff were educated by the DON/Designee regarding following interventions for fall risks and implementing/charting neurological assessments after a fall.
D. The DON/Designee will review the 24-hour report to identify any resident change in condition daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 5/12/2023

F725 Sufficient Nursing Staffing

The facility maintains sufficient staffing to maintain the highest practicable physical, mental, and emotional well-being of the residents.

A. Residents #6 and #12 no longer reside at the facility. Resident #10 has their call light answered timely to meet their needs.
B. Residents who have the potential to be affected by calling out or by needing assistance have been identified and will be responded to in a dignified and timely manner.
C. Staff have been educated by DON/Designee on resident’s who call out for assistance and require assistance, need to respond appropriately and check resident when calling out/pushing call light upon request. Residents are interviewed during Hall Hero rounds Monday through Friday mornings to ensure Resident Rights are being met and addressed and discussed in Morning Meeting.
D. The DON/Designee will review call light responses weekly to ensure they are responded to appropriately. The review of call light responses will be completed monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 5/26/2023