

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/05/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165540	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>KK on 10/11/10</u> B. WING _____		(X3) DATE SURVEY COMPLETED  R 09/23/2010
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 <u>10/11/10</u>  The following deficiencies are the result of the facility's annual health survey revisit and investigation of complaints # 30445-C and # 30702-C. The complaints were substantiated. (See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C).  {F 281} 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS SS=B  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on clinical record review, the facility failed to always follow Physician orders as written for 2 of 9 current residents reviewed (Residents #1 & #6). The facility identified a census of 30 current residents.  Findings include:  1. According to the MDS (minimum data set) assessment dated 9/5/10 Resident #1 had diagnoses that included hypertension, seizure disorder, anxiety disorder, glaucoma and allergies. The MDS identified the resident with short term memory problems and modified independence with cognitive skills for daily decision-making. According to the MDS the resident independent with bed mobility and transfers.  Review of the Physician's orders dated 8/1/10 revealed the following orders a. metoprolol tartrate (for high blood pressure) 25	{F 000}			
		{F 281}	See attached		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6120 MORNINGSIDE AVENUE</b> <b>SIOUX CITY, IA 51106</b>		
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{F 281}	<p>Continued From page 1</p> <p>mg (milligrams) bid (twice a day).</p> <p>b. melatonin 3 mg at hour of sleep (to enhance sleep).</p> <p>c. cosopt (for glaucoma) 0.5-2% 1 drop to both eyes bid.</p> <p>d. keppra (an anticonvulsant) 500 mg bid.</p> <p>e. mucinex (to reduce mucous) 600 mg bid.</p> <p>f. sodium chloride (to moisten nasal passages) 1 spray to each nare 3 times per day.</p> <p>g. Z bec (for wound healing) 1 tablet daily.</p> <p>Review of the MAR (medication administration record) dated September 2010 revealed the entry for metoprolol tartrate 25 mg bid, melatonin 3 mg at hour of sleep, cosopt 0.5-2% 1 drop to both eyes bid, keppra 500 mg bid, mucinex 600 mg bid, sodium chloride 1 spray to each nare 3 times per day and Z bec 1 tablet daily. Staff failed to document administration of the medications on 9/15/10 at 4:00 pm.</p> <p>2. According to the Face Sheet dated 9/14/10 Resident #6 had diagnoses that included vascular intestinal insufficiency, depressive disorder, hypothyroidism, degenerative intervertebral disc, hypertension, anxiety, diaphragmatic hernia, hypoosmolality, malignant neoplasm and hypocalcemia.</p> <p>Review of the Resident-Data Collection sheet dated 9/14/10 revealed the resident alert and disoriented to time. The collection sheet identified the resident required 2 person assist with transfers and assistance with eating.</p> <p>Admission orders dated 9/14/10 directed, in part, to administer amitriptyline-chlordiazepoxide (for depression) 12.5 mg-5 mg give ½ tablet every hour of sleep and Cyclosporine(an</p>	{F 281}			

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{F 281}	Continued From page 2 immunosuppressant agent) 0.05% 1 drop to both eyes bid.  Review of the MAR dated September 2010 revealed the entry for amitriptyline-chlordiazepoxide 12.5 mg-5 mg give ½ tablet every hour of sleep. Staff failed to document medication administration on 9/16/10. The MAR also listed Cyclosporine 0.05% 1 drop to both eyes bid. Staff failed to document administration of the medication on 9/15/10 or 9/16/10.	{F 281}			
{F 323} SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and staff interview, the facility failed to ensure planned interventions in place to prevent falls for 1 of 7 residents reviewed for supervision (Resident #3). The facility identified a census of 30 current residents.  Findings include:  1. According to the MDS (Minimum Data Set) assessment dated 9/12/10, Resident # 3 had diagnoses that included arteriosclerotic heart disease, hypertension, dementia other than	{F 323}		7/24/10	

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{F 323}	<p>Continued From page 3</p> <p>Alzheimer's disease, depression, asthma, epilepsy, esophageal reflux, osteoporosis and iron deficiency. The MDS identified the resident with short term memory problems and modified independence with cognitive skills for daily decision-making.</p> <p>Review of the care plan dated 7/1/10 revealed the resident with a history of falls and it directed staff to ensure non-skid strips on the floor beside the resident's bed and in front of the toilet.</p> <p>Observation on 9/21/10 at 8:20 am revealed the resident's room with no non-skid strips on the floor next to his/her bed or in front of the toilet.</p> <p>Observation on 9/23/10 at 9:00 a.m. revealed the resident's room with no non-skid strips on the floor next to his/her bed or in front of the toilet.</p> <p>During a interview with the Director of Nursing on 9/23/20 at 1:00 pm she stated that the resident moved to a different room and staff did not apply the non-skid strips.</p>	{F 323}			

OCT 06 2010

Provider number  
165540  
Countryside Nursing  
and Rehabilitation  
Center, LLC.  
6120 Morningside Ave  
Sioux City, Iowa  
51106

This is the Plan of  
Correction for the  
Federal comparative  
survey revisit and state  
survey finished on  
September 23, 2010.

The Plan of Correction  
as documented on the  
statement of  
deficiencies constitutes  
my credible allegation  
of compliance and all  
stated deficiencies  
would be corrected by  
date specified.

Preparation and/or execution of this Plan of  
Correction does not constitute admission or  
agreement by this provider of the truth of the  
facts alleged or conclusions set forth in the  
statement of deficiencies. The Plan of  
Correction is prepared and/or executed solely  
because provisions of the State law require it.

**ALL ITEMS WILL BE IN  
COMPLIANCE BY  
OCTOBER 11, 2010.**

F281

Resident #1 and #6 Medication Administration  
Record for September was reviewed by  
pharmacist and all unit dose cassettes had been  
returned to pharmacy empty, thus medications  
had been given but sign off on Med  
Administration Record had not been  
completed. All nursing personnel who is

responsible for Medication Administration for all residents will be inserviced on the five rights of Medication Administration. A double check system has also been instituted at shift change to review medication Administration records to assure all medications have been given and documented as given. DON and/or designee will audit weekly to see that all Medications are documented as given. DON and/or designee will monitor thru the QA process monthly for three months and then quarterly thereafter.

F323

Resident #3 care plan has been reviewed as of September 23, 2010 and updated to discontinue the non-skid strips by the bed and toilet. All resident care plans have been reviewed and updated to assure correct interventions are in place to care for resident. All staff have been inserviced on following Resident's care plans and updated care plan as needed. DON and/or designee will monitor care plans thru the QA process for three months and then quarterly there after.