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 _____	10/27/2016

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 11/27/16 The following deficiencies were identified during the facility's Skilled unit annual survey. Complaints #63831-C and 62836-C were not substantiated. See Code of Federal Regulations (45 CFR) Part 483, Subpart B-C.	F 000	Plan and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and/or State Law. Please accept this document as the facility's credible allegation of compliance.	
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure the presence of quarterly activities assessments for 4 of 9 current residents reviewed (Residents #2, #3, #4 and #6). The facility reported a census of 27 residents. Findings include: 1. Review of the MDS (minimum data set) assessment dated 9/16/16 for Resident #4 revealed diagnoses that included hypertension (high blood pressure), diabetes mellitus (high blood glucose) and hyperlipidemia (high cholesterol). The assessment documented Resident #4 entered the facility on 5/19/16.	F 248	**F 248** **Activities Meet Interests/Needs of Each Resident** The facility does provide an ongoing activities program designed to meet the interests and the physical, mental, and psychosocial well-being of each resident. As of November 15th, 2016, the Activity Director will chart activity assessments as required by the regulations. By November 27th, 2016, the Activity Director will have completed current activities assessments and progress notes for all residents. As of November 16th, 2016, Resident #4, Resident #2, and Resident #3 have current activities assessments and progress notes. All residents have the ability to be similarly affected. The Administrator will monitor completion of timely activity assessments. Activity Director was educated on November 14th, 2016 as to the requirements of F248.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/17/16

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.

POC accepted 11/28/16 VV

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 248	Continued From page 1 Review of electronic and paper medical record for Resident #4 revealed no quarterly activity note for August 2016. 2. Review of the quarterly MDS assessment dated 7/25/16 for Resident #6 revealed the resident had diagnoses that included hypertension, urinary tract infection, non-Alzheimer's dementia (memory loss), and depression (mood disorder). The assessment documented that Resident #6 entered the facility on 11/16/15. Review of the electronic and paper medical record for Resident #6, revealed no quarterly activity note for May 2016. 3. Review of 7/20/16 MDS assessment for Resident #2 revealed the resident had diagnoses that included Alzheimer's disease and anxiety. The assessment documented Resident #2 entered the facility on 8/29/13. Review of the Activity Progress notes for Resident #2 revealed no assessment progress notes from January 2016 to September 2016. 4. Review of the 10/10/16 MDS assessment for Resident #3 revealed diagnoses that included diabetes, hip fracture and severe kidney disease. The assessment documented that Resident #3 entered the facility on 1/20/16. Review of the Activity Progress notes for Resident #3 revealed no assessment progress notes from March 2016 to October 2016. An interview with the Administrator on 10/25/16 at 3:45 p.m. revealed the activity assessment should be done quarterly and they were not done prior to June. The prior activity director was terminated due to not completing activity	F 248	Activity Director will continue to ask residents for input on scheduled activities and special outings. Responsible Party: Administrator/Designee Completion Date: 11/27/16	

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F 248	Continued From page 2 assessments.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to develop care plan interventions for the use of psychotropic medications, monitoring for adverse side effects and fall prevention for 3 of 9 current residents reviewed (Residents #1, #7 and #9). The facility reported a census of 27 residents. Findings include:	F 279	**F 279** **Develop Comprehensive Care Plans** The facility does use the results of the assessment to develop, review, and revise care plans. The facility does develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. On November 15th, 2016, the MDS Coordinator developed care plan interventions for the use of psychotropic medications for Resident #1 and added specific staff instructions on how to keep Resident #1 safe regarding falls. On November 15th, 2016, the MDS Coordinator amended Resident #7's care plan to monitor side effects of psychotropic medication use and added a problem focus of falls. On November 15th, 2016, Resident #9's care plan was amended by the MDS Coordinator to include monitoring side effects of psychotropic medication use and the care plan indicates that staff should reference the possible side effects of the psychotropic medications listed on the MARs.	

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F 279	Continued From page 3 1. Review of the Minimum Data Set (MDS) assessment dated 8/19/16 revealed Resident #1 a Brief Interview for Mental Status (BIMS) score of zero, as the resident could not complete the test. The assessment documented Resident #1 had a diagnosis of Non-Alzheimer's dementia. The assessment documented the resident fell once in the month before admission to the facility. The MDS also recorded that Resident #1 received a daily antidepressant. The MDS Care area assessment (CAA) summary documented triggered care areas included falls and psychotropic drug use. The October 2016 MAR for Resident #1 documented s/he received Sertraline (an antidepressant) 25 milligrams (mg) 3 tablets once a day with a start date of 8/22/16. The resident also received Trazodone (another antidepressant) 100 mg 1 tablet at bedtime for insomnia with a start date of 8/21/16, Risperdal (an antipsychotic) 1 mg 1 tab one time a day for dementia with a start date of 8/21/16 and Ativan (an antianxiety) 23 times for increased anxiety during the month of October 2016. Resident #1's current care plan, with an initiation date of 8/25/16, revealed one intervention to monitor for increased risk for falls, but contained no specific staff instruction to promote the resident's safety. The care plan did not contain information on the resident's psychotropic medication use and possible side effects of the medications. The Incident Report dated 8/30/16 at 2:57 a.m. documented staff found Resident #1 on the floor. The resident received a skin tear to the left shin. According to the incident report, staff added a	F 279	All other residents that are currently receiving psychotropic medications have the potential to be similarly affected. MDS Coordinator was educated on how to develop proper care plan interventions for the use of psychotropic medications, monitoring adverse side effects and fall prevention on October 27th by Regional Clinical Director. Staff will be educated on the potential adverse side effects of psychotropic medications. Starting November 1st, an individualized flow-sheet was added to residents' MARS if they are on psychotropic medications, requiring nurses to monitor and record any adverse side effects related to the use of psychotropic medications. Director of Nursing will monitor compliance with care plan interventions and conduct weekly (x 4) and monthly (x 2) care plan audits to determine compliance with F 279. Results of the audits will be reported at QA meetings. Responsible Party: Director of Nursing/Designee Completion Date: November 15th, 2016	

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F 279	Continued From page 4 new intervention directing half hour checks. The Incident Report dated 9/25/16 at 3:30 p.m. documented the resident fell and had no injury. According to the incident report, staff updated the care plan to include an intervention to assist the resident to use the toilet every 2 hours when awake. Review of the Fall Event Checklist for the Licensed Nurse dated 9/25/16 revealed a check mark by Add a New Intervention to assist in preventing a recurrence of another fall event and to add to the incident/accident report and the resident's care plan. 2. The MDS assessment tool dated 7/4/16 recorded Resident #7 had a BIMS score of 7 which indicated moderate memory and cognitive impairment. The assessment documented s/he had diagnoses that included Alzheimer's disease, anxiety disorder and depression. The MDS revealed Resident #7 received an antidepressant for 6 out of 7 days. Review of the MDS CAA summary revealed triggered care areas included falls and psychotropic drug use and to proceed to falls care planning. According to the October 2016 MAR, Resident #7 received Sertraline (an antidepressant) 25 mg 1 tablet one time a day and 100 mg one time a day with a start date of 7/28/16 for depression. The resident also received Risperdal (antipsychotic) 0.5 mg twice a day for dementia with a start date of 9/28/16. Resident #7's current care plan, with an initiation date of 7/8/16, revealed one intervention to monitor for increased risk of falls. The care plan	F 279		

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F 279	Continued From page 5 did not reveal a problem focus of falls, psychotropic medication use and the possible side effects of those medications. An interview with the Director of Nursing (DON) on 10/27/16 at 8 a.m. revealed the need for fall problem and interventions on the plan even without a fall occurring. The DON also indicated that if a resident is on psychotropic medications that this should be addressed on the care plan and to monitor for side effects. 3. Resident #9's MDS assessment dated 7/20/16 documented s/he had a BIMS score of 15, indicating intact memory and cognition. The MDS identified the resident's diagnoses included manic depression (alternating high and low mood states), schizophrenia (disorder in which people interpret reality abnormally) and insomnia (difficulty falling and staying asleep). The assessment documented that Resident #9 received antipsychotic medication every day. Review of the October 2016 MAR revealed Resident #9 received Abilify (antipsychotic) 30 milligrams (mg) daily and Seroquel (an antidepressant) 400 mg daily. Review of Resident #9's Care Plan, revised 6/9/16, revealed a focus area of behavior problems related to schizophrenia. The Care Plan instructed staff to administer the resident's medications as ordered and to monitor/document side effects and effectiveness. However, the Care Plan did not list specific side effects to watch for. During interview on 10/26/16 at 3:15 p.m. the MDS Coordinator stated staff can reference a drug book that's at the front desk to learn what side effects to monitor for when a resident is on a psychotropic medication. She stated she will	F 279		

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F 279	Continued From page 6 start adding them to the resident's care plans.	F 279	F 431	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	**Drug Records, Label/Store Drugs & Biologicals** The facility does label drugs and biologicals in accordance with currently accepted professional principles On October 27th, 2016, blank labels were requested from Drilling Pharmacy so that nursing staff can use them to date eye drop containers upon opening. On October 31st, 2016, Countryside's contracted pharmacist was educated at the QA meeting on Countryside's citation regarding the eye drops containers needing to be dated upon opening. Contracted pharmacy will now provide labels on eye drops as requested. The Director of Nursing will do random weekly audits (x 4) and monthly (x 2) audits of medication carts to determine compliance with L 488. Audit results will be reported at QA meetings. On November 14th, 2016, the Assistant Director of Nursing put notes in the front of the MARs binders to let nurses know that eye drop containers need to be dated upon opening. Staff will be educated on importance of dating eye drops upon opening. Responsible Party: Director of Nursing/Designee Completion Date: 11/14/16	

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F 431	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to date opened bottles of ophthalmic solutions (eye drops). The facility reported a census of 27 residents. Findings Include: Observation on 10/26/16 at 2:40 p.m. of the odd and even medication carts revealed numerous eye drop containers without a date when opened and expiration date to discard after opening. Observation on 10/27/16 at 7:10 a.m. of the odd medication cart revealed bottles of Alphagan opthalmic (eye) drops, Travatan Z opthalmic drops 0.004%, and Timolol opthalmic drops 0.5% without an open date or date to discard after opening. The cart also stored 2 bottles of Olopatadine opthalmic solution 0.2% opened without a date opened or date to discard after opening. Observation on 10/27/16 at 7:30 a.m. of the even cart revealed Lumigansol opthalmic solution 0.01% and Azoptsus opthalmic solution opened without an open date or date to discard after opening. There were also 2 bottles of Timolol opthalmic Solution 0.5% and Azoptsus opthalmic solution without opened dates or dates to discard after opening.. The medication cart also contained Dorzolamide-Timolol opthalmic solution 0.5% without an open date or a date to discard after opening. Review of Eye Drop Expiration Guidelines on the website www.remedysrxsp.ca/pdf/eyedrop_tool.pdf	F 431		

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F 431	Continued From page 8 revealed that eye drops should be discarded 28 days after opening with some being discarded after treatment is complete. An interview with the Director of Nursing (DON) on 10/27/16 at 8 a.m. revealed the eye drop containers had never had an open date written on them and the facility always used the expiration date on the container. The DON indicated a plan to start placing open dates on eye drop container.	F 431		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA1075	A. BUILDING: _____ B. WING _____	10/27/2016

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

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L 000	Initial Comments Correction date 11/16/16 The following deficiencies result from the facility's annual Nursing facility health survey. Please see Iowa Administrative Code, Chapter 58.	L 000	Plan and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the Federal and/or State Law. Please accept this document as the facility's credible allegation of compliance. **L 488**	
L 488	58.21(14)a Drug, storage, and handling 481-58.21(135C) Drugs, storage, and handling. 58.21(14) Drug safeguards. a. All prescribed medications shall be clearly labeled indicating the resident ' s full name, physician ' s name, prescription number, name and strength of drug, dosage, directions for use, date of issue, and name and address and telephone number of pharmacy or physician issuing the drug. Where unit dose is used, prescribed medications shall, as a minimum, indicate the resident ' s full name, physician ' s name, name and strength of drug, and directions for use. Standard containers shall be utilized for dispensing drugs. Paper envelopes shall not be considered standard containers. (III) This Statute is not met as evidenced by: Based on observation, staff interview and review of professional literature, the facility failed to label medications for 1 of 1 nursing units observed. The facility reported a census of 13 residents. Findings include: 1. During medication room and medication cart check on 10/26/16 at 3:50 PM, with Staff A, registered nurse (RN), observation revealed one	L 488	**Drug, storage, and handling** It is the policy of our facility to label and store prescribed medications in accordance with currently accepted professional principles. On October 26th, 2016, the undated bottle of Latanprost ophthalmic solution was sent back to the pharmacy and a replacement was ordered. On October 27th, 2016, labels were requested from Drilling Pharmacy so that nurses will have the ability to date eye drop containers when they open them. On October 31st, 2016, Countryside's contracted pharmacist was educated at the quarterly QAPI meeting on Countryside's citation regarding the eye drop containers needing to be dated upon opening. Contracted pharmacy will now provide labels on eye drops as requested. On November 14th, 2016, the Assistant Director of Nursing put notes in the front of the MARs binders to let nurses know that eye drop containers need to be dated upon opening.	

POC accepted 11/28/16

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L 488	Continued From page 1 open and undated bottle of Latanprost opthalmic solution (medicated eye drop for glaucoma). Review of the facility's drug handbook entitled Mosby's 2015 Nursing Drug Reference revealed on page 685 that an opened Latanprost solution bottle should be stored at room temperature, protected from light for up to 6 weeks.	L 488	The Director of Nursing will do random weekly audits (x 4) and monthly (x 2) audits of medication carts to determine compliance with L 488. Audit results will be reported at QA meetings. Staff will be educated on importance of dating eye drops upon opening. Responsible Party: Director of Nursing Compliance Date: 11/14/16	
L 687	58.26(3)c(2) Resident activities program 481-58.26(135C) Resident activities program. 58.26(3) Duties of activity coordinator. The activity coordinator shall: c. Keep all necessary records including: (2) Individual resident progress notes recorded at regular intervals (at least quarterly). A copy of these notes shall be placed in the resident ' s clinical record; (III) This Statute is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to maintain quarterly (every 3 months) activity progress notes for 2 of 3 current residents reviewed (Residents #2 and #3). The facility reported a census of 12 residents. Findings included: According to the Admission Record dated 3/10/14, Resident #2 entered the facility on that date. According to the Admission Record dated 3/9/16, Resident #3 entered the facility on 3/8/16. Review of Resident #2's and Resident #3's	L 687	**L 687** **Resident Activities Program** As of November 15th, the Activity Director will chart activity assessments to meet regulatory compliance. As of November 16th, 2016, Resident #2 and Resident #3 have current activities assessments and progress notes. All residents have the ability to be similarly affected. Activity Director was educated on November 14th as to the requirements of L 687. The Administrator/Designee will monitor completion of timely activity assessments and progress notes. Activity Director will continue to ask residents for input on scheduled activities and special outings. Responsible Party: Administrator/Designee Completion Date: 11/16/16	

DEPARTMENT OF INSPECTIONS AND APPEALS

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L 687	Continued From page 2 clinical records revealed a lack of quarterly activity progress notes for either resident. During an interview with the Activity Director on 10/26/16 at 9:10 AM, she stated that her employment with the facility began around 7/1/16. She began documenting quarterly activity notes on the residents as they are due. The Activity Director stated she could not retrieve the notes once they were in the electronic medical records. During an interview with the Administrator on 10/27/16 at 9:10 AM, she stated she could not locate any quarterly activity notes for Residents #2 or #3.	L 687		