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 04/13/2023

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	F 000		
✓	Correction date: 5/12/2023 & 5/26/2023			
JB	The Countryside Health Care Center Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. The following deficiencies resulted from the investigation of complaints #109371, #109372, #110080, #110081, #110082, #110083, #110085, #110086, #110087, #110114, #110115, #110117, 110520, #110553, #110554, #110604, #110637, #110732, and #111360 conducted April 3, 2023 to April 13, 2023. Complaints #110083 and #110087 were not substantiated. Complaints #109371, #109372, #110080, #110081, #110082, #110085, #110086, #110114, #110115, #110117, #110520, #110553, #110554, #110604, #110637, #110732, #111360 were substantiated. A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspection and Appeals on April 3, 2023 to April 13, 2023. The facility was found to not be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total Residents: 53			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and	F 550	Jackie Loghry Pirner Administrator	5/19/2023

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.

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 04/13/2023

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 550	Continued From page 1	F 550		

access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility record,

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 04/13/2023

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 550	Continued From page 2	F 550		

facility policy, resident, and staff interviews, the facility failed to treat residents with dignity by not answering their call lights in a timely manner for 2 of 4 residents reviewed (Residents #2 and #25). The facility reported a census of 53 residents.

Findings include:

1. Resident #2's Minimum Data Set (MDS) assessment dated 2/10/23 identified a Brief Interview of Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS revealed Resident #2 required extensive assistance from two persons for transfers and toilet use. The MDS included diagnoses of monoplegia of lower limb affecting left nondominant side (paralysis of left lower limb), charcot's joint of left ankle and foot (nerve damage), left foot drop, and overactive bladder. The MDS listed Resident #2 as occasionally incontinent of urine and always incontinent of bowel.

On 4/10/23 at 3:36 PM Resident #2 reported that when her call light does not get answered in a timely manner, she becomes incontinent. During the interview, Resident #2 started crying and reported that when staff find her incontinent they get mad at her. Resident #2 reported that she, in turn, gets mad because it isn't her fault that she needs help and if the staff do not want to help then they should not work in a nursing home.

2. Resident #25's MDS assessment dated 1/10/23 identified a BIMS score of 14, indicating intact cognition. The MDS listed that Resident #25 required extensive assistance from one person with bed mobility and required extensive assistance from two persons with transfers. The

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 04/13/2023

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 550	Continued From page 3 MDS included a diagnosis of nontraumatic subarachnoid hemorrhage (bleeding in the brain by a broken blood vessel). On 4/11/23 at 10:59 AM, Resident #25 reported that she uses a call light to get help to get her legs into bed at bedtime. When she does not get her call light answered in a timely manner, she tries to get into bed on her own but it is hard to do and that makes her feel like she is not important enough to get the help she needs. The Respect and Dignity; Right to Personal Property, Including Searches and Illegal Substances policy reviewed October 2022 instructed that: a. Residents have the right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing as space permits unless to do so would infringe upon the rights and safety of other residents. b. Staff shall provide person-centered care that emphasizes the resident's comfort, independence, personal needs, and preferences. On 4/13/23 at 1:28 PM, the Director of Nursing (DON) reported that it could be possible for a resident's dignity to be negatively affected if it took too long to have a call light answered and that resident became incontinent.	F 550		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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 04/13/2023

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 609	Continued From page 4	F 609		

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility policy, facility records, and staff interview, the facility failed to notify the state agency that 1 of 4 residents reviewed (Resident #17) fell and died. The facility reported a census of 53 residents.

Findings include:

Resident #17's Minimum Data Set (MDS) assessment dated 1/3/23 listed an admission date of 12/30/22 from an acute (short-term) hospital. The MDS identified a Brief Interview of Mental Status (BIMS) score of 4, indicating

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 04/13/2023

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 609	Continued From page 5	F 609		

severely impaired cognition. The MDS listed that Resident #17 required the extensive assistance from two persons with bed mobility, transfers, and toilet use.

Resident #17's Admission History and Physical dated 12/22/22 signed by a Physician's Assistant revealed:
1. Resident #17 fell at her home on 12/20/22 and had two other falls in the prior four days.
2. Resident #17's diagnoses included the following:
a. UTI (urinary tract infection)
b. Dementia
c. Possible NSTEMI (a type of heart attack)

The Nurse's Note on 1/25/23 at 6:20 AM revealed that the Certified Medication Aide (CMA) called a nurse to Resident #17's room at 5:18 AM due to (due to) her not responding. Upon entry to Resident #17's room discovered her lying on a mattress beside her bed on her stomach with her head turned to the right side. The CMA and Registered Nurse (RN) rolled Resident #17 onto her left side. Resident #17 appeared pale, cold to the touch with her lips and nail beds cyanotic (blue). The nurse could not get a blood pressure (BP), an oxygen saturation (O2 sat), or a pulse. Resident #17 did have a respiratory rate of 6 with very shallow breathing. The nurse assessed her airway to ensure it did not have any blocking it, in which the nurse did not see anything visible. The nurse confirmed that Resident #17 had a do not resuscitate (DNR) code status. The CMA called 911 at 5:22 AM while the RN applied oxygen (O2) at 8 L (Liters) via a full-face mask. The CMA attempted to contact the Director of Nursing (DON) at 5:30 AM with no answer. The nurse made several attempts to obtain a complete set

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 04/13/2023

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 609	Continued From page 6	F 609		

of vital signs (VS) and arouse Resident #17, unsuccessfully. Resident #17 remained on her left side until the Emergency Medical Technicians (EMTs) arrived. The CMA reported that she passed Resident #17's early morning (AM) medications about 10 minutes prior. At that time Resident #17 appeared awake, alert, and took her pills without incident. While the CMA gave another resident their pills, the CMA heard the resident call out so she went to check Resident #17. When she entered Resident #17's room she found her on the mattress beside her bed with her stomach down on the mattress and she had head facing left. The CMA turned Resident #17's head to the right and found her not responding so she called the RN to assess the situation. The EMTs transported Resident #17 out of facility (OOF) at 5:42 AM to the emergency room (ER). The nurse called Resident #17's emergency contact at 5:45 AM and reported that Resident #17 became unresponsive, so they sent her to the ER. The nurse paged the physician at 5:47 AM and again at 6:09 AM. The facility received a call from the ER nurse at 6:11 AM that Resident #17 passed away in route to the ER. The nurse sent a text message and called the DON to notify her.

Resident #17's Certificate of Death revealed that she died 1/25/23 at 5:45 AM with a cause of death listed as atherosclerotic cardiovascular disease and the manner of death as natural.

The facility lacked documentation of notification to the state agency after Resident #17 fell and died on 1/25/23.

The Incident or Unusual Event Reporting, All Types policy with a last reviewed date of 10/22 revealed:

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 04/13/2023

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 609	Continued From page 7 a. The facility administration will report the following events to appropriate agencies per their existing guidelines: i. Death of a resident, employee or visitor because of unnatural causes (e.g. suicide, homicide, accidents, etc.). b. Unusual occurrences shall be reported to the appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations, example a suspected crime or serious injury within two hours. c. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) as required by federal and state regulations. 4. The administration will keep a copy of written reports on file. In an Electronic Mail (email) dated 4/5/23 at 12:56 PM, the Administrator reported that there were no incidents reported to the state agency in January 2023. In an interview on 4/6/23 at 8:47 AM, the DON reported that she reviewed the incident with the corporate nurse consultant who advised her to not report the fall with death to the state agency because the resident did not die as a result of the fall.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		

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 04/13/2023

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 610	Continued From page 8	F 610		

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility records, facility policy, and staff interview the facility failed to investigate falls by completing a comprehensive incident report for 2 of 4 residents reviewed (Resident #4 and #15). The facility reported a census of 53 residents.

Findings include:

1. Resident #4's Minimum Data Set (MDS) assessment dated 2/16/23 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of parkinson's disease, pneumonia, non-Alzheimer's dementia, respiratory failure, and osteoarthritis. The MDS indicated that Resident #4 required extensive assistance from one person with transfers and toilet use.

The Nurses Note dated 1/5/23 at 7:20 PM indicated that staff heard a resident calling for help saying help Resident #4 is on the floor. Staff

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 04/13/2023

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 610	Continued From page 9	F 610		

found Resident #4 on the floor wearing only a brief, laying on his back with blood oozing from his head and right hip. The nurse applied gauze, abdominal pad (Abd), and wrapped it around Resident #4's head. An assessment revealed Resident #4's vital signs as temperature 98.1, pulse 85, respirations 22, blood pressure (bp) 115/66, oxygen saturation (O2 sat) 94% on room air (RA). Resident #4 denied any pain and neurological (neuro) checks started. Resident #4 stated to get him off the floor. Resident #4 reported being okay and that he did not need to go to the hospital. He explained that he wanted to get over there and lost his balance. The nurse calmed Resident #4 down and notified his daughter, who requested to send him to the local hospital. The nurse called an ambulance, got a doctor's order to send Resident #4 to the emergency room (ER), and notified the Director of Nursing (DON).

Resident #4 lacked an Incident Report related to his fall in the Risk Management of the electronic health record (EHR).

2. Resident #15's MDS assessment dated 1/26/23 identified a BIMS score of 11, indicating moderately impaired cognition. The MDS indicated that Resident #15 required limited assistance from two persons with bed mobility, transfers, and toilet use. The MDS included diagnoses of non-Alzheimer's dementia, schizophrenia, and a history of falling.

Progress Notes revealed the resident had falls on the following dates:
a. 10/26/22
b. 10/27/22
c. 11/21/22

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 04/13/2023

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 610	Continued From page 10	F 610		

d. 12/29/22
e. 1/7/23
f. 1/14/23
g. 1/17/23
h. 2/9/23
i. 3/23/23

The EHR Risk Management section for stuck out incidents revealed that Resident #15 listed falls on 1/7/23 and 3/11/23 with a line through them.

The EHR Risk Management Summary lacked incident reports related to Resident #15.

In an Electronic Mail (email) on 4/4/23 at 2:34 PM, the Administrator reported that all incident reports are located in the Risk Management section of the EHR.

In an email on 4/4/23 at 3:30 PM the Administrator explained that the nurses have progress notes in the EHR that also refer to the Incident but most of their notes are in the Incident Report. The Administrator reported that the facility had no other paper files.

In an email on 4/13/23 at 10:49 AM the Administrator reported that our Regional Director of Clinical Services said there is no regulation related to incident reports and we are not required to have a policy. She said incident reports are an internal program for facility reporting and state surveyors should not have access to review them. I have copied our Regional Director of Clinical Services on this email, so you can ask her any further questions in regards to the policy. Please note that she may have a delay in responding due to her flight schedule that day.

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 04/13/2023

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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy the facility failed to complete an accurate Minimum Data Set (MDS) assessment for 1 of 25 residents (Resident #22). The facility reported a census of 53 residents. Findings include: Resident #22's Minimum Data Set (MDS) assessment dated 3/20/23 identified a Brief Interview of Mental Status (BIMS) score of 14, intact cognition. The MDS indicated he required limited assistance from one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed that Resident #22 did not have a risk for a pressure ulcer/injury. The MDS listed that Resident #22 had one stage one pressure ulcer and used a pressure reducing device in his chair and bed. Resident #22 had nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, and applications of ointment/medications other than to his feet. The MDS included diagnoses of pneumonia, anemia, diabetes mellitus, malnutrition, depression, bipolar disorder, respiratory failure, hemothorax, pleural effusion, and alcohol dependence. The Care Plan revised 3/8/23 lacked any documentation of Resident #22's pressure ulcer(s) or interventions for staff to care for Resident #22's pressure ulcer.	F 641		

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 04/13/2023

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 641	Continued From page 12	F 641		

A Braden Risk assessment completed on 3/8/23 listed a score of 18, indicating at risk for developing pressure ulcers.

Another Braden Risk assessment completed on 3/15/23 listed a score a 17, indicating at risk for developing pressure ulcers.

An Admission Assessment dated 3/15/23 at 2:07 PM indicated that Resident #22 admitted from the hospital with a pressure ulcer to his coccyx that measured 3 centimeters (cm) by (x) 2 cm.

A nurse's note dated 3/20/23 at 10:42 AM documented that Resident #22 had an intact blister to his left heel.

On 4/11/23 at 1:21 PM the MDS Coordinator reported that she reviews a resident's skin assessment and she puts her eyes on the resident when she completes the skin section of the MDS. When queried about Resident #22 differing documentation on his 3/20/23 MDS related to pressure ulcers and his Braden score on 3/15/23 listed him as being at risk with two pressure ulcers, the MDS replied that she wondered if his mobility had changed and that was why. She explained that he started to work with therapy and thrived. Resident #22 helped more with repositioning and she based her decision off of that. When asked if another Braden scale should be completed she agreed that one should be done.

On 4/11/23 at 1:30 PM the Assistant Director of Nursing (ADON) indicated that she would consider Resident #22 at risk for developing pressure ulcers.

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 04/13/2023

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 641	Continued From page 13 On 4/12/23 at 2:12 PM the DON stated Resident #22's MDS should have him listed as being at risk for developing pressure ulcers. Any changes in his activity would not affect his MDS regarding the risk for a pressure ulcer, because he had pressure ulcers. The MDS Assessment Coordinator Policy approved in May 2022 directed that each individual who completed a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section is completed.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		

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 04/13/2023

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 655	Continued From page 14	F 655		

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility policy, and staff interview, the facility failed to develop a baseline care plan within 48 hours of admission for 1 of 5 reviewed (Resident #18). The facility reported a census of 53 residents.

Findings include:

Resident #18's Minimum Data Set (MDS) assessment dated 1/31/23 listed an admission date of 1/27/23. The MDS identified a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition.

The Care Plan revealed an initiated date of

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 04/13/2023

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 655	Continued From page 15 1/30/23 and had only two areas of Focus. The Resident/Resident Representative Care Conference Review form dated 1/31/23 revealed: 1. The type of conference: 72-hour 2. A blank space to answer the question that Resident #18 received Baseline Care Plan/orders in 48 hours. The Baseline Care Plan policy reviewed October 2022 instructed that a baseline care plan would be developed within 48 hours of the resident's admission. On 4/13/23 at 1:28 PM the Director of Nursing (DON) reported that she expected Baseline Care Plans to be completed within 48 hours.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		

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 04/13/2023

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 656	Continued From page 16	F 656		

under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff interview and policy review the facility failed to develop a care plan to address antibiotic usage, anticoagulant usage, anti-anxiety medication usage, opioid medication usage, antidepressant medication usage and side effects to watch for in 4 out of 12 residents (Resident #1, 2, 21, and 22) reviewed for comprehensive care plans. The facility also failed to address activities of daily living (ADLs), the presence of a pressure ulcer on a resident's coccyx and heel along with

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 04/13/2023

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 656	Continued From page 17	F 656		

interventions on the care plan. The facility reported a census of 53 residents.

Findings Include:

1. Resident #1's Minimum Data Set (MDS) assessment dated 11/18/22 identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS documented that she required extensive assistance from two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated she received an antibiotic for 4 out of the 7 days in the lookback period. The MDS included diagnoses of osteomyelitis (bone infection), diabetes mellitus, cellulitis (skin infection with swelling), obesity, right eye blindness, chronic obstructive pulmonary disease (COPD, chronic lung disease).

The Admission Summary dated 11/14/22 at 1:29 PM indicated that Resident #1 readmitted to the facility due to cellulitis in her left lower leg and right foot, an acute (short-term) urinary tract infection (UTI), elevated troponin (protein found in the muscle of the heart), and atrial fibrillation (abnormal pumping of the heart that causes an abnormal heart rate). Medication changes included: apixaban (blood thinner) 5 milligrams (mg) 1 tablet every 12 hours for 90 days, metoprolol tartrate (high blood pressure) 25 mg 1 tablet every 12 hours and daptomycin (antibiotic) 500 milligrams (mg) intravenously (IV) 4 mg/kilogram (kg) everyday for 28 days until 12/6/22.
The November 2022 Medication Administration Record (MAR) contained an order for daptomycin (antibiotic) 650 milligram (mg) intravenously (IV)

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 04/13/2023

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 656	Continued From page 18	F 656		

one time a day for osteomyelitis of the foot, lower extremity cellulitis for 26 days.

The December 2022 MAR contained the following order: daptomycin 650 mg IV one time a day for osteomyelitis of the foot, lower extremity cellulitis for 26 days.

The Hospital Discharge Summary dated 11/3/22-11/14/22 indicated Resident #1 should take the following medication: apixaban (blood thinner) 5 milligrams (mg) oral tablet every 12 hours for 90 days. For atrial fibrillation; discontinuing apixaban increases the risk of thrombotic events. If discontinuing for a reason other than pathological bleeding, consider administering another anticoagulant. Check daily for signs of bleeding and notify the physician if bleeding is noted.

The Care Plan Focus dated 12/12/22 identified a diagnosis of congestive heart failure. The Care Plan directed staff to give her cardiac medications as ordered and to monitor for any signs and symptoms of congestive heart failure. The Care Plan lacked documentation that Resident #1 had received an antibiotic for 28 days and was on an anticoagulant. The care plan lacked what staff were to monitor for while the resident was on an antibiotic and anticoagulant.

The November 2022 Medication Administration Record (MAR) documented Resident #1 started an apixaban 5 mg 1 tablet every 12 hours on 11/28/22. The MAR also documented she started daptomycin 500 mg on 11/15/22.

On 4/12/23 at 2:12 PM the Director of Nursing (DON) stated Resident #1's Care Plan should

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 04/13/2023

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 656	Continued From page 19	F 656		

have indicated she was on an IV antibiotic and an anticoagulant to include what staff should be aware of while on those medications.

2. Resident #21's MDS dated 11/18/22 identified a BIMS score of 13, indicating intact cognition. The MDS documented that she required extensive assistance of two persons of bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS included diagnoses of osteomyelitis (bone infection), diabetes mellitus, cellulitis (skin infection), obesity, right eye blindness, chronic obstructive pulmonary disease (COPD, long-term lung disease).

The Care Plan revised 4/4/23 for Resident #21 lacked documentation related to her activities of daily (ADLs) and how many staff should assist her.

On 4/12/23 at 2:12 PM the DON acknowledged that Resident #21's Care Plan should include her ADLs and the required amount of staff assistance for Resident #21.

3. Resident #22's MDS assessment dated 3/20/23 identified a BIMS score of 14, indicating no cognitive impairment. The MDS indicated he required limited assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed that he had one stage 1 pressure ulcer and used a pressure reducing device in his chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, and applications of ointment/medications other than to his feet. The MDS included diagnoses of pneumonia, anemia, diabetes mellitus, malnutrition (lack of minerals and vitamins), depression, bipolar disorder (mood

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 04/13/2023

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 656	Continued From page 20	F 656		

imbalance), respiratory failure, hemothorax (blood around the lungs), pleural effusion (fluid around the lungs), and alcohol dependence.

The Care Plan revised 3/8/23 lacked documentation of Resident #22's pressure ulcer(s). The Care Plan lacked interventions for staff to implement and follow while caring for Resident #22's pressure ulcer.

The Admission Assessment note dated 2/22/23 at 3:16 PM indicated that Resident #22 admitted to the facility from the hospital with a pressure ulcer to his coccyx and to his left heel.

On 4/11/23 at 1:30 PM the Assistant Director of Nursing (ADON) stated the MDS Coordinator completes the Care Plans and it should include his pressure ulcers with interventions.

On 4/12/23 at 2:12 PM the DON indicated Resident #22's pressure ulcers and interventions should be on the Care Plan. She verified the MDS Coordinator completed the residents' Care Plans.

4. Resident #2's MDS assessment dated 2/10/23 identified a BIMS score of 12, indicating moderately impaired cognition. The MDS identified Resident #2 required extensive assistance of two persons with bed mobility, transfers and toilet use. Resident #2 required total assistance of one person with baths. The MDS indicated that Resident #16 did not ambulate and required a wheelchair for locomotion. The MDS included diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection), anxiety disorder, depression, and encephalopathy (swelling on the brain). Resident #2 took an antianxiety medication and 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 04/13/2023

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 656	Continued From page 21	F 656		

antidepressant medication for seven out of seven days in the lookback period. Resident #2 took an opioid medication for six out of seven days in the lookback period.

Review of the physician orders signed 1/6/23 revealed the following orders:
a. Tramadol HCL tablet (opioid or pain medication) two times a day and as needed for pain with a start date of 11/4/22
b. Citalopram (antidepressant medication) 40 mg (milligrams) at bedtime with a start date of 11/4/22
c. Clonazepam (anti-anxiety medication) 0.25 mg at bedtime with a start date of 11/4/22
d. Amoxicillin (antibiotic medication) 250 mg daily for urinary tract infection prophylaxis with a start date of 11/5/22

The Care Plan dated 12/15/22 lacked personalized documentation pertaining to the residents usage and side effects to watch for with antibiotic medication usage, anti anxiety medication usage, opioid medication usage, and antidepressant medication usage.

The Care Plan dated 12/15/22 lacked personalized documentation related to ADLs and how to safely care for Resident #2. The Care Plan lacked directions related to how to assist Resident #2 with bed mobility, transfers, ambulation, locomotion, dressing, eating, personal hygiene, toileting, and bathing.

The Comprehensive Care Plans policy revised August 2022 instructed it is the facility policy to develop and implement an Individualized Comprehensive Person Centered Care Plan that included measurable objectives and time frames

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 04/13/2023

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 656	Continued From page 22 to meet the resident's medical, nursing, mental, cultural, and psychological needs are developed for each resident. The policy continued to direct that the Comprehensive Care Plan is based on thorough assessment that includes, but is not limited to, the MDS and physician orders. The policy documented assessments of residents are ongoing and Care Plans are revised as information about the resident and the resident's condition change. On 4/11/23 at 1:15 p.m. the MDS Coordinator verified that Resident #2 did not have a Comprehensive Care Plan that addressed pertinent medications and ADLs. The MDS Coordinator stated she would update the Care Plan right away.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy review the facility failed to following physician's orders for 1 of 3 (Resident #1) residents reviewed. Resident #1 did not receive one of their medications ordered when they admitted to the facility on 11/14/23 for 14 days. The pharmacy delivered the medication on 11/14/23, a nurse on-duty signed out the order but failed to transcribe the order to Resident #1's medication administration record (MAR) ensure that they received the medication as ordered. The	F 658		

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 04/13/2023

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 658	Continued From page 23	F 658		

facility reported a census of 53 residents.

Findings include:

Resident #1's Minimum Data Set (MDS) assessment dated 11/18/22 identified a Brief Interview for Mental Status (BIMS) score of 13, indicating no cognitive impairment. The MDS documented that she required extensive assistance from two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated she received an antibiotic for 4 out of the 7 days in the lookback period. The MDS included diagnoses of osteomyelitis (bone infection), diabetes mellitus, cellulitis (skin infection with swelling), obesity, right eye blindness, chronic obstructive pulmonary disease (COPD, chronic lung disease).

The Admission Summary dated 11/14/22 at 1:29 PM indicated that Resident #1 readmitted to the facility due to cellulitis in her left lower leg and right foot, an acute (short-term) urinary tract infection (UTI), elevated troponin (protein found in the muscle of the heart), and atrial fibrillation (abnormal pumping of the heart that causes an abnormal heart rate). Medication changes included: apixaban (blood thinner) 5 milligrams (mg) 1 tablet every 12 hours for 90 days, metoprolol tartrate (high blood pressure) 25 mg 1 tablet every 12 hours and daptomycin (antibiotic) 500 milligrams (mg) intravenously (IV) 4 mg/kilogram (kg) everyday for 28 days until 12/6/22.

The Nurses Note dated 11/29/22 at 3:19 PM indicated that Resident #1 returned from the hospital on 11/14/22 with new orders for apixaban

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 04/13/2023

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 658	Continued From page 24	F 658		

5 mg daily for 90 days. The medication did not get added to the MAR, therefore the medication just started on 11/28/22. The nurse notified the medical doctor (MD) who directed to complete the 90 days for the medication starting on 11/28/22. The MD explained that Resident #1 did not receive any adverse effects from not starting the medication.

The Hospital Discharge Summary dated 11/3/22-11/14/22 indicated Resident #1 should take the following medication: apixaban (blood thinner) 5 milligrams (mg) oral tablet every 12 hours for 90 days. For atrial fibrillation; discontinuing apixaban increases the risk of thrombotic events. If discontinuing for a reason other than pathological bleeding, consider administering another anticoagulant. Check daily for signs of bleeding and notify the physician if bleeding is noted.

The November 2022 Medication Administration Record (MAR) documented Resident #1 started an apixaban 5 mg 1 tablet every 12 hours on 11/28/22.

On 4/6/23 at 2:14 PM when asked what should be completed after a resident returns to the facility from the hospital with new orders, Staff K, Licensed Practical Nurse (LPN) replied that a Registered Nurse (RN) handles the medications; usually the Director of Nursing (DON) or the Assistant Director of Nursing (ADON). When asked why Resident #1 did not start their order for apixaban for 14 days, she answered that she did not know because she only worked weekends.

On 4/11/23 at 10:23 AM the pharmacy reported

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 04/13/2023

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 658	Continued From page 25	F 658		

they received the e-script for Resident #1's apixaban order on 11/14/22. At that time, they filled the order, delivered it to the facility, and Staff J LPN signed the receipt on 11/14/22 at 9:40 PM.

On 4/11/23 at 12:33 PM Staff J explained that when the pharmacy brought in a new order, the pharmacy staff member and she would scan in all the medications box by box, then put them away. When asked who puts the new orders in their Electronic Health Record (EHR), she stated the admitting nurse does that. She did not remember when the pharmacy delivered Resident #1's new apixaban order and reported that she had no idea why it did not get started.

On 4/11/23 at 1:30 PM the ADON explained that when Resident #1 readmitted to the facility her order must have been missed. When a medication error is discovered she reports it to the DON and she handles it from there. She indicated that usually when a resident is readmitted to the facility they already have their medications at the facility. So, when the admitting nurse reconciles the medications along with the discharge medication list, they check for medications that may not be in the facility.

On 4/12/23 at 2:12 PM the DON does not believe she remembered how Resident #1's apixaban order got missed. She remembered that she notified the doctor and he sent an order for the medication to start the day of discovery. She stated the order totally got missed and did not get transcribed on to the MAR.

The Admission to the Facility policy approved March 2023 instructed that prior to or at the time of admission, the physician must provide the

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 04/13/2023

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 658	Continued From page 26 facility with information needed for the immediate care of the resident, including orders covering at least: medication orders including a medical condition or problem associated with each medication.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interviews, staff interviews and facility policy review the facility failed to provide bathing assistance twice weekly and/or per resident preference for 4 of 4 residents reviewed for bathing (Residents #2, #16, #20, #4). The facility reported a census of 53 residents. Findings include: 1. Resident #2's Minimum Data Set (MDS) assessment dated 2/10/23 identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #2 required extensive assistance of two persons with bed mobility, transfers and toilet use. Resident #2 required total assistance of one person with baths. The MDS indicated that Resident #16 did not ambulate and required a wheelchair for locomotion. The MDS included diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection), anxiety disorder, depression, and encephalopathy (swelling on the brain). Resident	F 677		

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 04/13/2023

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 677	Continued From page 27	F 677		

#2 took an antianxiety medication and an antidepressant medication for seven out of seven days in the lookback period. Resident #2 took an opioid medication for six out of seven days in the lookback period.

On 4/11/23 at 2:00 p.m. Resident #2 reported that she did not get her showers as she should have, adding that some weeks she got one shower and other weeks she did not get a shower at all.

The Care Plan dated 12/15/22 did not address showers or bathing.

The undated Weekly Shower/Whirlpool Schedule sheet listed Resident #2's bath days are Wednesdays and Fridays.

The Body Audit paper forms for 11/4/22 - 3/31/23 lacked documentation to indicate Resident #2 received a bath or a shower on the following dates:
a. November 2022
    i. 16 - 25
    ii. 17 - The comments section indicated that Resident #2 did not receive a shower due to short staff.
b. December 2022
    i. 7 - 12
    ii. 4, 8 - lacked documentation but included a nurse aide signature.
c. January 2023
i. 13 - 19
d. February 2023
    i. 4 - 9, 11 - 16
e. March 2023
    i. 23 - 28

The POC Response History reviewed on 4/12/23

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 04/13/2023

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 677	Continued From page 28	F 677		

from 12/13/22 until 4/12/23 listed Resident #2's baths are scheduled for Tuesdays and Thursdays. The POC Response History lacked documentation to indicate Resident #2 received a bath/shower on the following dates
a. 1/13/23 - 1/19/23
b. 2/14/23 - 3/23/23 indicated response not applicable
c. 3/24/23 - 4/12/23 lacked documentation

The clinical record lacked documentation of any other attempts to encourage Resident #2 to bathe or that she refused to bathe.

2. Resident #16's MDS assessment dated 3/23/23 identified a BIMS score of 3, indicating severely impaired cognition. The MDS identified Resident #16 required total assistance of two persons with bathing. The MDS included diagnoses of hypertension, diabetes mellitus, anxiety disorder, depression, and cerebral infarction (stroke).

On 4/12/23 at 10:00 AM observed Resident #20 sitting in the dining room in a wheelchair with long facial hair and not shaved.

The Care Plan dated 11/9/22 did not address showers or bathing.

The undated Weekly Shower/Whirlpool Schedule sheet listed Resident #16's bath days are Wednesdays and Fridays.

The Body Audit paper forms for 11/1/22 - 2/28/23 lacked documentation to indicate Resident #16 received a bath or a shower on the following dates:
1. November 2022

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 04/13/2023

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 677	Continued From page 29 a. 3 - 8, 12 - 22 b. 30 - refused 2. December 2022 a. 8 - 13 3. January 2023 a. 12 - 16, 19 - 24 4. February 2023 a. 9 - 14, 16 - 21 b. 10 - refused The November 2022 Follow Up Question Report related to ADL - Bathing Wednesday and Friday lacked documentation to indicate Resident #16 received a bath/shower on the following dates 11/12/22 - 11/22/22. 11/4/22 documented the response as not applicable and 11/30/22 indicated that Resident #16 refused a bath. The December 2022 Follow Up Question Report related to ADL - Bathing Wednesday and Friday lacked documentation to indicate Resident #16 received a bath/shower on the following dates 12/1/22 - 12/7/22. 12/9/22 documented the response as not applicable. The January 2023 Follow Up Question Report related to ADL - Bathing Wednesday and Friday lacked documentation to indicate Resident #16 received a bath/shower on the following dates 1/7/23 - 1/10/23 and 1/9/23 - 1/24/23. 1/13/23 and 1/20/23 documented the response as not applicable. The February 2023 Follow Up Question Report related to ADL - Bathing Wednesday and Friday lacked documentation to indicate Resident #16 received a bath/shower on the following dates 2/9/23 - 2/14/23, 2/16/23 - 2/21/23. 2/10/23 documented the response as not applicable.	F 677		

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 04/13/2023

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 677	Continued From page 30	F 677		

The March 2023 Follow Up Question Report related to ADL - Bathing Wednesday and Friday lacked documentation to indicate Resident #16 received a bath/shower on the following dates

The clinical record for the Resident #16 lacked documentation of any other attempts to encourage the resident to bathe or re-approached when the resident had refused a bath.

3. Resident #20's MDS assessment dated 3/1/23 identified a BIMS score of 6, indicating severely impaired cognition. The MDS identified Resident #20 required total assistance of one person with bathing. The MDS included diagnoses of coronary artery disease (damaged arteries in the heart), neurogenic bladder (bladder issues due to the nervous system), non-Alzheimer's dementia, multiple sclerosis (disabling disease of the brain and spinal cord), and depression.

The Care Plan dated 3/15/23 indicated that Resident #20 required total assistance with bathing from one person.

The undated Weekly Shower/Whirlpool Schedule sheet listed Resident #20's bath days are Mondays and Thursdays.

Review of the bathing records from 11/1/22-2/28/23 lacked documentation that he received a bath in
1. November 2022 on
    a. 8 - 20, 29 - 30
    b. 10 - refused
    c. 14 The comments section indicated that Resident #20 did not receive a shower due to short staff.

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 04/13/2023

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 677	Continued From page 31	F 677		

d. 17- documentation revealed the bath was not given due to short staffing.
2. December 2022 on
a. 1 - 4
b. 8, 15, and 19 - refused
c. 22 - hospitalized
3. January 2023 on
a. 3 - 8, 17 - 25
b. 5 and 23 - refused
4. February 2023 on
a. 3 - 8, 14 - 18, 24 - 26

The POC Response History reviewed on 4/12/23 from 12/12/22 until 4/12/23 listed Resident #2's baths are scheduled for Tuesdays and Thursdays. The POC Response History lacked documentation to indicate Resident #2 received a bath/shower on the following dates
a. December 2022
i. 15 and 23 - refused
ii. 22 - not applicable
b. January 2023
i. 5 - refused
ii. 19 - Not applicable
c. March 2023
i. 17 - 22. 28 -31
ii. 23 - Not applicable
d. April 2023
i. 1 - 5
ii. 3 - Not applicable

The clinical record for the Resident #20 lacked documentation of any other attempts to encourage the resident to bathe or re-approached when the resident had refused a bath.

A facility untitled and undated memo located in the facility shower book directed staff to offer a shower later if a resident refused their shower

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 04/13/2023

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 677	Continued From page 32	F 677		

and if the resident refused a second time to notify the nurse so the nurse can offer the shower. The memo further directed that if the resident refused for the nurse then the nurse must make a progress note and offer the resident a shower the following day.

On 4/11/23 at 4:58 p.m. the Assistant Director of Nursing (ADON) reported that if a resident refused a bath she expected the staff to re-approach them. If the resident continued to refuse then she expected the staff to give the resident a bed bath and document it.

On 4/12/23 at 7:45 AM the Director of Nursing (DON) verified she did not have any additional bathing documentation for Residents #2, #16, and #20. The DON stated she expected the staff to offer a bath at least weekly but she preferred them to offer a bath two times a week. The DON said she followed the Nebraska state regulations on bathing requirements and did not know the Iowa regulations.

4. Resident #4's Minimum Data Set (MDS) assessment dated 2/16/23 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of parkinson's disease, pneumonia, non-Alzheimer's dementia, respiratory failure, and osteoarthritis. The MDS indicated that Resident #4 required extensive assistance from one person with transfers and toilet use.

The undated Weekly Shower/Whirlpool Schedule sheet listed Resident #4's bath days are Wednesdays and Fridays.

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 04/13/2023

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 677	Continued From page 33	F 677		

The Task area in the resident's Electronic Health Record (EHR) revealed the resident was scheduled to receive baths on Wednesday and Friday.

The Body Audit form
a. Lacked documentation to indicate Resident #4 received a bath
    i. November 2022 on 3 - 8 and 10 - 22
    ii. January 2023 on 7 - 17
    iii.February 2023 on 9 - 14 and 16 - 21
b. Documentation indicated that Resident #4 refused a bath on:
    i. 11/11/22 - only shaved due to Resident #4's refusal.
    ii. 2/10/23

The clinical record lacked documentation of any other attempts to encourage Resident #4 to bathe or that she refused to bathe.

The Shower/Tub Bath Policy dated May 2022 listed the purpose of the procedure as to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin. The policy further directed the following information to be recorded in the resident's medical record:
a. Date and time the resident received their shower or tub bath.
b. The name and title of the individual who assisted the resident with the shower/tub bath.
c. All assessment data obtained during the shower/tub bath.
d. How the resident tolerated the shower/tub bath.
e. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken.
f. The signature and title of the person recording

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 04/13/2023

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 677	Continued From page 34 the data.	F 677		
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 record review, staff interview and facility policy review the facility failed to assess and intervene when a resident had a change of condition for 2 of 10 residents reviewed (Resident #5 and Resident #12). The lack of assessment and interventions resulted in harm to Resident #12. The facility reported a census of 53 residents. Findings include: 1. Resident #12's Minimum Data Set (MDS) assessment dated 3/1/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of diabetes, cellulitis (skin infection), heart failure, sepsis (blood infection), cirrhosis of the liver, and pulmonary hypertension (high blood pressure affecting the lungs). The MDS indicated that Resident #12 required extensive assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene.	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 04/13/2023

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 35	F 684		

The Advanced Wound and Hyperbaric Center progress notes dated 10/22/21 at 9:00 AM indicated the Plan as Resident #12 to discharge from the Wound Care Center and to follow-up with her Primary Care Provider (PCP) as needed or for any other medical concerns. The Edema Control listed that Resident #12 wore a Compreflex (velcro wraps used to control swelling or edema) for compression to her bilateral lower legs. Resident #12 worked with a contracted Occupational Therapy (OT) Registered/Licensed (R/L) at the nursing home. The order directed to care at the home rehab/lymphedema continues with lymphedema pumps.

The Care Plan Focus revised 12/2/22 indicated that Resident #12 had a potential skin impairment to her skin's integrity due to edema and weeping from lymphedema. The Invention dated 4/17/22 directed for Occupational Therapy (OT) and Nursing to treat per orders.

The N Weekly Nursing Assessment dated 12/1/22 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. The right lower front leg included a description that Resident had bilateral lower extremities skin issues due to cellulitis. The assessment identified the areas as not new for Resident #12.

The N Weekly Nursing Assessment dated 12/8/22 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had open areas from cellulitis to both of her legs. The assessment identified the areas as not new for Resident #12.

The Care Conference Note dated 12/14/22 at 6:58 AM labeled as Late Entry indicated that

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 04/13/2023

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 36	F 684		

Resident #12 explained that her right leg wept a lot. She said the nurses did a pretty good job being consistent with her dressing changes, but she would like it if they could do it more consistently on the weekends too. Resident #12 reported that her leg treatments only got done once per day on the weekends if she was lucky. Resident #12 expressed that at one time her right leg looked really good and she would like it to return to that.

The N Weekly Nursing Assessment dated 12/15/22 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had open areas from cellulitis to both of her legs. The assessment identified the areas as not new for Resident #12. The writer explained that she could do a wound follow-up with Resident #12 every Monday to see how many times she got her dressings done. That was if one particular person did not do it, they could take corrective action. The treatment is ordered three times a day and is charted as being completed.

The N Weekly Nursing Assessment dated 12/22/22 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had open areas from cellulitis to both of her legs. Resident #12 also had a scattered skin rash spread out with some open due to scratching. The assessment identified the areas as not new for Resident #12.

The Handwritten Orders dated 12/23/22 written by the OT directed the staff to continue to check Resident #12's right lower extremity (RLE) each shift and left lower extremity (LLE) daily. Lotion could be applied to the LLE to help release dried skin. RLE check every shift, cleanse and change

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 04/13/2023

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 37	F 684		

if dressing wet on the evening and nights. Day shift to cleanse and change daily. If Resident #12 complained of pain in one leg, using the compression pump on the leg that is not sore. Apply Compreflex daily on thigh, calf, and foot as this provides long-term compression all day.

The N Weekly Nursing Assessment dated 12/29/22 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. Resident #12's left lower leg had cellulitis with no drainage, while her right lower leg had cellulitis with an open area that drained greenish clear fluids. The assessment identified the areas as not new for Resident #12.

The N Weekly Nursing Assessment dated 1/5/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had open areas from cellulitis to both of her legs. The assessment identified the areas as not new for Resident #12.

The N Weekly Nursing Assessment dated 1/12/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had scattered open areas on the back of both of her legs. The assessment identified the areas as not new for Resident #12 and directed to see the Treatment Medication Administration Record (MAR).

The N Weekly Nursing Assessment dated 1/15/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had reddened open moisture related wounds with serosanguineous (clear to pink drainage) yellow, green drainage, and foul odor noted to the right lower extremity. Resident #12 had a deep

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 04/13/2023

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 38	F 684		

indentation noted between her right inner ankle and her foot. The nurse notified Resident #12's PCP. The assessment identified the areas as new for Resident #12.

The Nurses Note dated 1/16/23 at 1:19 PM indicated that Resident #12 had an appointment scheduled with the Advanced Registered Nurse Practitioner (ARNP) on 1/18/23 due to increased weeping, yellow/green serosanguineous drainage, and a foul odor coming from her leg. Resident #12 saw the OTR/L who educated her that she did not need an appointment to see a physician but suggested increasing treatment for edema wraps to three times a day. Afterwards, Resident #12 explained that she did not want to go see a physician. The nurse educated Resident #12 on the signs and symptoms of infection. Resident #12 acknowledged understanding and explained that she would see how she felt on Wednesday. At that point she would decide on whether or not she would go to her appointment.

The N Weekly Nursing Assessment dated 1/19/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had an open area to her lower leg from cellulitis. The assessment identified the areas as not new for Resident #12.

The Nurses Note dated 1/20/23 at 11:45 AM indicated that Resident #12 complained of hallucinating to the bath aide and the CMA that morning but denied the complaints to the nurse. The nurse notified Resident #12's PCP of her possible hallucinations and refusal to be seen at her appointment due to increased weeping, foul odor, and edematous to her bilateral lower legs. Resident #12 did have a telehealth appointment

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 04/13/2023

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 39	F 684		

scheduled for that coming Monday (1/23/23) at 12:15 PM. The physician gave orders to send Resident #12 to the hospital for increased hallucinations or signs or symptoms of sepsis.

The signed verbal order dated 1/20/23 to send Resident #12 to the emergency room (ER) for hallucinations included an order dated 1/23/23 to restart cefdinir (antibiotic) 300 milligrams one tablet twice daily for ten days.

Review of orders written on 1/22/23 by the OTR/L revealed that staff were to continue to check Right Lower Extremity (RLE) dressings each shift, on evenings and nights, and only change if wet. Days were to check and change daily, cleanse, apply abdominal (ABD) gauze pad, wrap in kerlix (roll of woven gauze) and apply Compreflex compression garment on thigh, calf and foot. For the Left Lower Extremity (LLE), they were to change daily on days only using ABDs, kerlix and Compreflex.

The Telehealth Appointment note dated 1/23/23 included a new order for Cefdinir 300 milligrams one tablet twice daily for ten days.

The Nurses Note dated 1/24/23 at 4:03 PM indicated the facility received a fax from Resident #12's PCP regarding drainage from her legs. The PCP gave a new order to get a wound culture from cellulitis discharge.

The N Weekly Nursing Assessment dated 1/26/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had left leg-cellulitis but the nurse could not assess as Resident #12 refused to have her leg unwrapped. The right leg had cellulitis with

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 04/13/2023

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 40	F 684		

whitish-green drainage from it. The assessment identified the areas as not new for Resident #12.

The Nurses Note dated 1/28/23 at 1:37 PM listed that Resident #12 should continue on cefdinir for ten days for cellulitis to her RLE. Her RLE continued to weep heavily, saturating the dressing with a foul-smelling odor noted.

The Nurses Note dated 1/29/23 at 12:17 AM indicated that Resident #12 remained on antibiotic therapy for cellulitis to her right leg with no adverse (out of the ordinary) reactions noted. Her right leg appeared beefy red with moderate weeping noted but with no increase in warmth. The nurse completed the treatment per her order. Resident #12 denied pain or discomfort.

The Orders - Administration Note dated 1/30/23 at 12:33 PM listed that the nurse held Resident #12's leg pumps due to pain from her lymphedema abscess, pain, and drainage.

The Physician Communication Form dated 2/2/23 indicated that the lab called to report a correction on the wound culture performed on 1/25/23. The lab reported Proteus Mirabilis as isolated in the culture. The physician responded with no new orders.

The N Weekly Nursing Assessment dated 2/2/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. She had cellulitis to both of her legs, but Resident #12 refused to let the nurse complete a full skin assessment. The right leg had open areas with fluid drainage from it due to the cellulitis. The assessment identified the areas as not new for Resident #12.

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 04/13/2023

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 41	F 684		

The Orders - Administration Note dated 2/5/23 at 11:27 AM indicated that Resident #12 refused her leg pumps to be used for 45 minutes after her leg treatment due to continued drainage where the abscess sac fell off.

The N Weekly Nursing Assessment dated 2/9/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. Her left leg appeared swollen with erythema. The right leg appeared swollen with draining. The assessment identified the areas as not new for Resident #12. The form described that besides swelling and erythema on both legs no observation of other skin issues for that shift's assessment.
The N Weekly Nursing Assessment dated 2/16/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. Resident #12 had lymphedema to her lower and upper legs. OT works with her for Wrapping and edema wear. Resident #12 has bilateral compression pumps she is to wear daily for 45 minutes to one hour. Her right leg weeps more than her left leg. The assessment identified the areas as not new for Resident #12.

The Handwritten Orders dated 2/20/23 written by the OTR/L instructed that per doctor's orders (and if their orders do not state the exact same thing, then they need to get a new order).
a. Apply and use compression pumps daily.
b. Immediately after pumps are removed, Compreflex must go on over the edema wear.
i. Green stripe - thigh
ii. Red stripe - calf
iii. Yellow stripe - foot
iv. Compreflex on thigh, calf, and foot.

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 04/13/2023

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 42	F 684		

Please, Certified Nurse Aides (CNAs), CMAs, and Registered Nurses (RN) make sure the Compreflex is applied immediately after the pumps. Obviously, the legs fill with fluid without compression. Please follow these orders daily as it did not occur consistently. An additional note indicated that regardless of what the Medication Administration Record (MAR) states, the Compreflex are not going on Resident #12 about 30-40% of the time that the OTR/L comes. Otherwise, they don't get on her until late in the day, hours without pumps, and by then the legs are full.

The N Weekly Nursing Assessment dated 2/23/23 displayed that Resident #12 Shower Skin Assessment revealed alterations to her skin. The assessment identified the areas as not new for Resident #12. No description provided for the skin alteration.

Resident #12's February 2023 Treatment Administration Record (TAR) included documentation that RNs, Licensed Practical Nurses (LPN), and CMAs did her treatments to her lower legs.

The Nurses Note dated 3/1/23 at 3:39 pm indicated resident #12's PCP got notified that she had recent complaints of right flank pain with lower back pain. Resident #12's urine appeared amber (dark yellow/orange color) with sediment (skin tissue). Resident #12's PCP gave an order to send Resident #12 to the ER of her choice. The nurse notified Resident #12's family who would meet her at the ER.

The Orders - Administration Note dated 3/10/22 at 3:06 AM the overnight nurse reported that

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 04/13/2023

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 43	F 684		

Resident #12 died in the hospital on Wednesday, 3/8/23.

On 4/5/23 at 1:45 PM Staff L, CMA/Scheduler, reported that Resident #12 did not have any open areas to her legs when she worked the medication cart. Staff L added that the only treatment she did involve changing the ABD pad when it got full from Resident #12's leg weeping. She explained that she used a spray wound cleanser with the ABD pad change.

On 4/5/23 at 2:30 PM, Staff U, CNA/CMA, stated that Resident #12 had an open area to the back of her right lower leg that looked like a blister. He explained that he thought staff could have done a better job of taking care of her wound. He reported that one weekend in early February another CMA cared for Resident #12 during the day. When he came in in the afternoon, the previous CMA reported that Resident #12 refused her dressing change that morning. He explained that he went to her room and asked her if anyone changed her dressing that morning. Resident #12 responded that she did not because reported being too busy. Staff U reported that sometimes Resident #12 did refuse her dressing changes.

On 4/6/23 at 1:35 PM the PCP's nurse the PCP did prescribe antibiotics a couple of times for Resident #12's upper arm and lower leg cellulitis, but she saw the Infectious Diseases and Wound Center for her cellulitis.

In a follow-up interview on 4/6/23 at 1:47 PM, Staff L reported the drainage color as clear and that its drained fluid from the edema. When questioned if the ABD ever had yellow or green drainage, she replied that it might have once or

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 04/13/2023

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 44	F 684		

twice. Staff L added that it might have had a bad smell. She said that due to it being a long time ago, she couldn't remember because she left doing the medication cart and became a scheduler instead.

In a follow-up interview on 4/6/23 at 2:50 PM Staff U, said her dressing did have some yellow and green watery drainage off and on. Staff U explained that it occurred more so before she went to the hospital. He added that her wound did smell bad, but he did not know if the smell came from her leg or her feet since he was down by her foot. He described her entire right lower leg as a dark red in color.

On 4/10/23 at 9:40 AM Staff K, LPN, she explained that the OTL/R took care of Resident #12's lymphedema wraps. She explained that the only treatment Resident #12 had included orders for her right leg wound to put an ABD on the weeping area and wrap it with kerlix. She explained that Resident #12's leg had mostly clear drainage, but it still smelled foul and had drainage at times of yellow and/or green. She reported being in the room with the OTL/R when she told Resident #12 that she did not need to see a physician. Staff K added that in her opinion, that is why Resident #12 refused to go. Staff K said that they made a telehealth appointment instead for Resident #12 and started her on an antibiotic. She stated that she mentioned to the Director of Nursing (DON) that Resident #12s should see a wound specialist, but the DON told her that they did not have wound care there.

On 4/11/23 at 1:05 PM the OTL/R stated that she treated residents with lymphedema for two years both at home and at the facility. She said that

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 04/13/2023

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 45	F 684		

both Resident #12's legs had severe edema and wept profusely. She explained that the right leg wept so bad that she increased the dressing changes from daily to each shift and as needed. She reported that she felt that Resident #12 received sketchy wound care from the facility staff. She added that she had a conversation with the DON about it and for a while she saw some improvement. She stated that staff only touched the outside of the normally dry wrap and thought that it didn't need to be changed. However, in reality the wrap hid a soaked ABD. She explained that if Resident #12's dressings got changed as ordered, she would not have needed to have them changed so often. She reported that the facility had many different staff responsible for changing the dressing. The OTL/R explained that everyone thought that someone else should change them. When asked about the color and odor of drainage, she stated that off and on she saw yellow and/or green, foul smelling drainage from both of her legs. She did not feel Resident #12's legs had an infection, but felt that she had an internal infection that drained from the lymph system out of her legs.

On 4/13/23 at 1:10 PM the DON denied knowing that CMA's could not do dressing changes. The DON disagreed that nurses documented that Resident #12 had cellulitis because they could not diagnose.

2. Resident #5's MDS assessment dated 3/30/23 identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of hypertension (high blood pressure), pneumonia, stroke, Parkinson's disease, left lower leg fracture, seizures and respiratory failure. The MDS listed that Resident #5 required limited

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 04/13/2023

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 46	F 684		

assistance from one person with transfers, dressing, and personal hygiene.

The Care Plan Focus dated 12/15/22 indicated that Resident #5 had a risk for altered skin integrity due to immobility. The Interventions directed the following:
a. Initiated 10/1/20: Weekly skin assessments.
b. Revised 5/16/22: Daily skin observation with cares

On 4/3/23 at 10:55 AM observed a few scattered flat red spots above and below Resident #5's right inner elbow area. Resident #5 reported that she had them for about two and a half weeks. Resident #5 expressed that some of the areas were going away. She added that at first, they itch more at night but they started to itch some during the day too. Resident #5 stated the facility did not do anything for the rash.

The N Weekly Nursing Skin Assessment dated 3/7/22 listed that Resident #5 did not have any alterations in skin integrity.

The N Weekly Nursing Skin Assessment dated 3/15/23 indicated that Resident #5 had redness below her breasts.

The N Weekly Nursing Skin Assessment dated 3/21/23 listed that Resident #5 continued to have a small red rash to both of her arms, abdomen, and legs.

The week of 3/28/23 lacked a documented assessment.

The N Weekly Nursing Skin Assessment dated 4/4/23 Resident #5 continued to have a rash to

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 04/13/2023

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 47 her arms, abdomen, and legs. The comments related to description of new areas if applicable directed to see the treatment MAR for Resident #5's progress. Resident #5's April 2023 Treatment Administration Record (TAR) listed an order dated 11/2/21 to complete weekly skin checks every Tuesday night. The TAR lacked any additional orders related to the treatment of Resident #5's rash. Resident #5's clinical record lacked documentation that they notified the physician related to her rash. The Pressure Injury/Skin Breakdown-Clinical Guidelines revised May 2021, directed that based upon need and results of the evaluations, the staff will implement interventions for the prevention and care of skin issues. On 4/13/23 at 1:10 PM the Director of Nursing explained that she was pretty sure that someone already addressed Resident #5's rash.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		

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 04/13/2023

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 686	Continued From page 48	F 686		

necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, facility policy review, staff, and resident interviews, the facility failed to complete weekly skin assessments and thorough skin assessments for 2 of 4 residents reviewed (Residents #21 and #22) with pressure ulcers. In addition, the facility failed to initiate and carry out interviews for 1 of 4 residents reviewed (Resident #22) with a pressure ulcer, resulting in a decline of his pressure ulcer. The facility reported a census of 53 residents.

The Minimum Data Set (MDS) assessment identifies the definition of pressure ulcers:

Pressure Ulcer Stage Definitions

Suspected Deep Tissue Injury purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II partial thickness loss of dermis presenting as a shallow open ulcer with a red

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 04/13/2023

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 686	Continued From page 49	F 686		

pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Stage III full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable Ulcer: inability to see the wound bed

Findings include:

1.Resident #21's Minimum Data Set (MDS) assessment dated 3/28/23 identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The MDS indicated she required extensive assistance from one person for bed mobility, toilet use, personal hygiene, and extensive assistance of two persons for transfers and dressing. The MDS indicated that she had a risk for developing pressure ulcers/injuries and had one stage one unhealed pressure ulcer/injury. The MDS listed that Resident #21 received treatments included pressure reducing devices on her chair and bed, turning/repositioning program, pressure ulcer/injury care, and applications of ointment/medications other than to her feet. The MDS included diagnoses of nontraumatic intracerebral hemorrhage (brain bleed), hypertension (high blood pressure), diabetes mellitus, malnutrition (lacking minerals or vitamins), obstructive hydrocephalus (fluid in the

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 04/13/2023

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 686	Continued From page 50	F 686		

brain), chronic kidney disease and atrial fibrillation (the heart pumps out of normal causing an irregular heart rate).

The Care Plan Focus dated 3/24/23 indicated Resident #21 had actual impairment to her skin integrity and fragile skin resulting in a coccyx wound. The Interventions directed the staff to monitor and document the location, size, and treatment of the skin injury.

The March 2023 Treatment Administration Record (TAR) contained the following order:
-Weekly skin assessment one time a day every Thursday with a start date of 3/23/23 and discontinue date of 3/30/23. The order got documented on 3/23/23 as being completed, but lacked documentation to indicate completion on 3/30/23.

The April 2023 TAR contained the following order:
-Weekly skin assessment one time a day every Monday. Start date of 4/3/23

The Admission Assessment dated 3/23/23 at 2:34 PM identified that Resident #21 came to the facility from the hospital. Resident #21's skin appeared warm, dry, and intact. The assessment revealed no open areas/skin issues at the time of the assessment.

The facility failed to complete a skin assessment on 3/23/23 and 3/30/30 as ordered.

The ADON's personal weekly wound assessment spreadsheet dated 3/27/23 - 4/2/23 listed that Resident #21 had a stage III wound to her coccyx that measured 1.2 cm x 1 cm. The wound appeared open, with a pink wound base and

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 04/13/2023

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 686	Continued From page 51	F 686		

macerated (softened skin by moisture) edges.

When asked on 4/11/23 to provide Resident #21's skin assessment since her admission of 3/23/23, the facility provided the following assessments:
- The N Weekly Nursing Skin Assessment dated 4/3/23 indicated that Resident #21 had alterations in her skin integrity. She had a pressure wound to her coccyx that measured 0.1 cm x 0.1 cm x 0.1 cm. The assessment lacked a description of the appearance of the wound.
- The N Weekly Nursing Skin Assessment dated 4/10/23 indicated that Resident #21 had alterations in her skin integrity. She had a pressure ulcer that measured 0.1 cm x 0.1 cm x 0.1 cm. The note indicated they would continue her current treatment of Triad (specialized wound ointment) three times a day. The assessment lacked a location and a description of the appearance of the wound.

The ADON's personal weekly wound assessment spreadsheet dated 4/3/23-4/9/23 listed that Resident #21 had a stage III wound to her coccyx that measured 0.5 cm x 1.2 cm x 0.1 cm. The wound appeared open, with a pink wound base and macerated (softened skin by moisture) edges.

A weekly nursing skin assessment completed on 4/10/23 related to the 3/23/23 admission documented a 0.1 cm x 0.1 cm pressure ulcer. The area continued to measure 0.1 cm x 0.1 cm on the skin assessments completed on 4/3/23 and 4/10/23.

Resident #21's clinical record lacked the weekly wound assessments provided by the ADON.

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 04/13/2023

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 686	Continued From page 52	F 686		

2. Resident #22's MDS assessment dated 3/20/23 identified a BIMS score of 14, indicating no cognitive impairment. The MDS indicated he required limited assistance of one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed that he had one stage 1 pressure ulcer and used a pressure reducing device in his chair and bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, and applications of ointment/medications other than to his feet. The MDS included diagnoses of pneumonia, anemia, diabetes mellitus, malnutrition (lack of minerals and vitamins), depression, bipolar disorder (mood imbalance), respiratory failure, hemothorax (blood around the lungs), pleural effusion (fluid around the lungs), and alcohol dependence.

The Hospital's Discharge Summary dated 2/22/23 regarding discharge equipment and supplies listed an order for Resident #22's left heel to apply a small Mepilex border dressing to the bulla on his left heel for protective purposes, offload with a pillow, and change every three days.

The ADON's personal weekly wound assessment spreadsheet dated 2/20/23 - 2/26/23 listed that Resident #22 had stage III wound to his coccyx that measured 3 cm x 2.9 cm x 0.3 cm. The description listed the wound as open with slough (stringy dying tissue) tissue. In addition, the spreadsheet included a stage I wound to his left heel that measured 1 cm x 1 cm, the description indicated the wound appeared red and still intact.

The Communication provided to the Physician on 2/27/23 at 2:00 PM notified the Physician of a fluid filled blister to Resident #22's left heel that measured 2.5 cm x 2.7 cm. The nurse indicated

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 04/13/2023

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 686	Continued From page 53	F 686		

that they cleaned the area and covered it with an island dressing. The note included a request for any new orders. The physician replied on 3/19/23 and sent back to the facility on 3/20/23. The facility's staff noted the order on 3/20/23.

The Communication provided to the Physician on 2/28/23 identified that Resident #22 had an intact blister to his left heel. The nurse requested an order for Prevalon boots with the direction of on when in bed, offload heels from bed, and to leave shoes off until healed? The note included unsigned handwriting that the Physician addressed on his previous fax.
On 4/6/23 at 9:58 AM the Assistant Director of Nursing (ADON) completed Resident #21's treatment of her coccyx. The area appeared open with a white wound bed, pink tissue in the center, and measured 0.5 centimeters (cm) by (x) 1.2 cm.

Resident #22's February 2023 TAR contained the following orders:
- Apply a small Mepilex border dressing to the bulla (large blister containing fluid) on left heel for protective purposes, off load with a pillow, and change every 3 days with a start date of 2/23/23.
- Cleanse coccyx ulcer with normal saline, apply Santyl (special wound ointment), then apply an Allevyn sacrum dressing, change daily one time of day with a start date of 2/23/23.
- Weekly skin assessment every Wednesday with a start date of 2/22/23 and discontinued on 3/5/23.

The ADON's personal weekly wound assessment spreadsheet dated 2/27/23 - 3/5/23 listed that Resident #22 had stage III wound to his coccyx that measured 3 cm x 2.9 cm x 0.3 cm. The

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 04/13/2023

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 686	Continued From page 54	F 686		

description listed the wound as open with slough (stringy dying tissue) tissue. In addition, the spreadsheet included a stage I wound to his left heel that measured 1 cm x 1 cm, the description indicated the wound appeared red and still intact.

The N Weekly Nursing Skin Assessment dated 3/7/23 indicated that Resident #22 had an alteration in his skin integrity due to a blister to his left heel with peeling skin.

Resident #22's Braden Risk Assessment completed on 3/8/23 listed a score of 18, indicating a risk for developing pressure ulcers/injuries.

The Care Plan revised 3/8/23 lacked documentation of Resident #22's pressure ulcer(s). The Care Plan lacked interventions for staff to implement and follow while caring for Resident #22's pressure ulcer.

The N Weekly Nursing Skin Assessment dated 3/11/23 indicated that Resident #22 had an alteration in his skin integrity of a coccyx ulcer with a daily wound dressing and a left heel blister with peeling skin.

The ADON's personal weekly wound assessment spreadsheet dated 3/6/23 - 3/12/23 listed that Resident #22 had stage III wound to his coccyx that measured 3 cm x 2.9 cm x 0.3 cm. The description listed the wound as open with slough (stringy dying tissue) tissue. In addition, the spreadsheet included a stage I wound to his left heel that measured 1 cm x 1 cm, the description indicated the wound appeared red and still intact.

An After-Visit Summary dated 3/11/23-3/15/23

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 04/13/2023

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 686	Continued From page 55	F 686		

documented the following dressing and wound orders: wound location-buttocks, apply a Mepilex sacral border dressing every three days and as needed. Apply prophylactically (as protection) to clean, dry, intact skin to prevent sacral ulcers every three days and as needed. The order instructs to lift and reattach the dressing for skin inspection per facility policy for skin care.

Resident #22's Braden Risk Assessment completed on 3/15/23 listed a score of 17, indicating a risk for developing pressure ulcers/injuries.

The N Weekly Nursing Skin Assessment dated 3/25/23 indicated that Resident #22 had alterations in skin integrity but no new areas.

Resident #22's March 2023 and April 2023 TAR contained the following orders:
- Apply a small Mepilex border dressing to the bulla on the left heel for protective purposes, off load with a pillow, change every 3 days with a start date of 2/23/23
- Cleanse coccyx ulcer with normal saline, apply Santyl, then apply an Allevyn sacral dressing, change once daily with a start date of 2/23/23.
- Triad Hydrophilic Wound paste to coccyx daily with dressing changes with a start date of 3/16/23.
- Weekly skin assessments every Saturday with a start date of 3/11/23

The N Weekly Nursing Skin Assessment dated 4/1/23 indicated that Resident #22 had an alteration in his skin integrity due to a pressure area to his coccyx that measured 1 cm x 0.5 cm. The nurse applied current treatment with Mepilex to the area.

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 04/13/2023

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 686	Continued From page 56	F 686		

The ADON's personal weekly wound assessment spreadsheet dated 3/27/23 - 4/2/23 listed that Resident #22 had stage III wound to his coccyx that measured 1 cm x 0.5 cm. The description listed the wound as open with slough (stringy dying tissue) tissue. In addition, the spreadsheet included a stage I wound to his left heel that measured 1.5 cm x 1 cm.

The N Weekly Nursing Skin Assessment dated 4/6/23 lacked any documentation.

On 4/6/23 at 10:16 AM observed Resident #22 lying in bed on his back wearing black shoes without having his feet offloaded, with his green Prevalon boot in the chair, and the waffle cushion on his wheelchair seat. Watched the Assistant Director of Nursing (ADON) complete his treatments and dressing changes to his coccyx and left heel. His left heel dressing had no date and the blister measured 1 cm x 1 cm. The blister appeared intact with an open area to the bottom left of the blister, the ADON did not measure that open area. Resident #22's dressing removed from his buttock listed a date of 4/5/23. The area measured 0.5 cm x 0.7 cm and appeared to have an open white area at the top of his coccyx with very superficial (not deep) shearing (removal of skin in one direction) below that area. Staff S, Certified Nursing Assistant (CNA), assisted with the treatment. After the ADON completed the treatment, Staff S left his shoes off while he stayed in bed. The Prevalon boot remained in his chair, no observation of pillows found in his room other than the one used for his head, and no noted positioning wedges present. When asked what things they did to help prevent further issues, Staff S replied that they did not offload his

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 04/13/2023

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 686	Continued From page 57	F 686		

feet at the time, but they assisted him with repositioning in bed. The ADON explained that she measures the wounds weekly and reports her findings to the Administrator.

On 4/7/23 at 3:47 PM Staff N, Certified Medication Aide (CMA), stated they got Resident #22 up for his meals and repositioned him every two hours. At least that's what she does when she works. When asked what they do to assist with healing and protecting his heel blister, she stated she did not notice anything with his feet. She added that he came to the facility with the Prevalon boot but did not know when the facility stopped using it. When asked when the blister on his heel opened, she stated she did not know he had a blister on his heel.

The ADON's personal weekly wound assessment spreadsheet dated 4/3/23 - 4/9/23 listed that Resident #22 had stage III wound to his coccyx that measured 0.5cm x 0.7 cm. The description listed the wound as healing open with pink slight slough tissue. In addition, the spreadsheet included a stage II red blister wound to his left heel that measured 1 cm x 1 cm. The area continued to still be half open stage I red blister with an intact area.

The Electronic Health Record (EHR) failed to include documented weekly skin assessments for Resident #22's coccyx pressure wound and Resident #22's left heel blister on 2/22/23, 3/1/23, 3/11/23, 3/18/23, 3/25/23, and 4/8/23. The left heel blister also lacked a documented weekly skin assessment for 4/1/23.

Resident #22's clinical record lacked the weekly wound assessments provided by the ADON.

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 04/13/2023

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 686	Continued From page 58	F 686		

On 4/11/23 at 10:42 AM witnessed Resident #22 not in bed and only one pillow remained in his room on his bed. His green Prevalon boot laid on the floor. Resident #22 noted in the commons area by the nurse's station wearing black shoes, with foot pedals on his wheelchair, with feet resting on the foot pedals. At 3:34 PM observed Resident #22 in bed, lying on his back, wearing his black shoes and his feet touched the footboard. Witnessed the green Prevalon boots on the floor under his bed.

On 4/11/23 at 1:30 PM the ADON stated Resident #22 has a mattress top to help with his pressure ulcers. She added that he has a Prevalon boot that he is supposed to wear every day to help protect/cushion his left heel. The nurses told her though that he refused to wear it. When asked if he should be wearing his shoes she replied that his shoes add a layer of protection. When Resident #22 came to the facility his heel just had a blister on it, it then popped, and opened. She thought he had his coccyx wound on admission as well. When asked when wound assessments should be completed she stated on admission a nurse should complete a full assessment. Her nurses are her eyes when it comes to the wounds and will report to her if a resident has an open area then she will go look at it. Skin assessments should be completed weekly. She is working with nurses to complete the measurements with the dressing changes because there are times when she wants to see the wound, the dressing and treatment are already completed and she does not want to take that dressing off. When asked if Resident #21 or Resident #22 had additional wound assessments as their electronic health records (EHR) lacked weekly assessment, she

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 04/13/2023

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 686	Continued From page 59	F 686		

answered that she completes her own assessments weekly that she puts on a spreadsheet and emails to the Administrator. The ADON reported they are not in the resident's clinical record.

On 4/11/23 at 2:00 PM observed Resident #22 lying in bed, on his back, black shoes on, without his feet offloaded. When asked if the staff ask him to wear the green boot on the floor under his bed, Resident #22 said no. He indicated he would wear it if the staff asked him. He said they did not take his shoes off while he laid in bed but he would allow them to take them off if they asked him. Resident #22 added that they did not put pillows under his feet while he laid in bed but would allow them to do so.

On 4/11/23 at 3:35 PM Staff J, Licensed Practical Nurse (LPN), explained that Resident #22 should be repositioned every two hours from side to side. Staff J added that at times he repositioned himself and could be noncompliant with staying on his side. She stated he should have a boot on while in bed and not wear his shoes. She added there are times he is pretty good with wearing boots.

On 4/11/23 at 5:49 PM Staff Q, CMA, stated they repositioned Resident #22 and ensured he did not sit up very long. Staff Q added that she felt he complied with this. Staff Q indicated she did not know he had a blister on his left heel.

On 4/11/23 at 6:04 PM Staff V, CMA, reported that she did not know he had a blister or a wound on his left heel.

On 4/11/23 at 6:45 PM Staff P, CMA, stated they

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 04/13/2023

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 686	Continued From page 60	F 686		

usually repositioned Resident #22 in his bed or chair. They would try to float his heels while in bed, leave his shoes on, and make sure nothing would rub against his heel. She indicated they used pillows and positioning wedges but never noticed the use of a Prevalon boot. Staff P added that Resident #22 is not a morning person, so he would be noncompliant but later in the afternoon he would be more cooperative.

On 4/11/23 at 8:00 PM Staff T, CMA, explained that Resident #22 is to be repositioned and they are to elevate his feet off the mattress. He does move by himself but will be compliant with repositioning on the overnight shift. When asked how they elevate his feet she indicated they will use a pillow or two. When asked if he is to wear the Prevalon boot that is in his room, she stated no one had told her he needed it.

On 4/12/23 at 10:24 AM observed Resident #21 sitting in his wheelchair in the commons area wearing shoes with his feet on the foot pedals. The Prevalon boots remained on the floor under his bed with only one pillow observed in his room and no positioning wedges noted.

On 4/12/23 at 2:12 PM when asked how they are prevented new wounds and assisted with healing Resident #22's wounds, the Director of Nursing (DON) replied that they completed incontinent cares and repositioning. The staff remind him to reposition because he can and will reposition himself side to side. He will sit up in his wheelchair, just needs to be reminded to reposition himself. For his heel it is to be offloading while in bed with pillows or those green positioning wedges, or his Prevalon boot. After notification of Resident #22 only having one pillow

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 04/13/2023

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 686	Continued From page 61	F 686		

in his room, no positioning wedges, and his Prevalon boot in his chair or on the floor the last two days she said ok. After informing the DON that Resident #22 indicated he would allow pillows and the use of his Prevalon boot, as well as allowing staff to remove his shoes while in bed, she stated ok. When asked if his shoes should be off she indicated she would need to see the wound herself to determine that.

On 4/13/23 at 11:49 AM witnessed Resident #21 sitting in his wheelchair being assisted to the dining room wearing his black shoes and his feet on the foot pedals. The green Prevalon boot remained on the floor under his bed with only one pillow in his room, and no positioning wedges in his room.

Resident #22's Progress Notes lacked documentation related to interventions that did not work or of him refusing interventions.

The facility's Pressure Injury/Skin Breakdown-Clinical Guidelines approved in June 2022, instructed the staff to complete an evaluation of the resident's skin and resulting risk factors for developing pressure ulcers upon admission. The staff are to examine the skin of a new admission and/or re-admission for ulcerations or indications of a Stage 1 pressure area that has not yet ulcerated at the surface. The nursing staff will complete an evaluation of the skin weekly. Based upon the need and results of the evaluations the staff will implement interventions for the prevention and care of skin issues. The Interdisciplinary Team (IDT) will review measures upon admission, quarterly, and with significant changes.

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 04/13/2023

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 689	Continued From page 62	F 689		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	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, staff interviews, and facility policy review the facility turned off the door alarms and failed to assure that staff monitored residents to prevent one from leaving without staff knowledge. This failure resulted in the likelihood of serious harm, serious injury, serious impairment, or death resulting in an Immediate Jeopardy to the health, safety, and security of the residents for 2 of 2 residents reviewed (Residents #4 and #17). Resident #17 had a known history or attempting to self-transfer, wander, and needing staff assistance of one person. On 1/25/23, the staff found Resident #17 not responsive lying on a mattress of the floor beside her bed. The facility sent her to the hospital by ambulance. The facility received a call from the hospital that she passed away in the ambulance on the way to the hospital. Resident #4's floor alarm did not work from 11/27/22 - 1/5/23 and he fell from his bed on 1/5/23. Resident #4 received a laceration to his head and required four staples.

The State Agency informed the facility of the Immediate Jeopardy (IJ) that began on April 4, 2023 at 11:30 AM. The Facility Staff removed the Immediate Jeopardy on April 5, 2023 through the

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 04/13/2023

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 689	Continued From page 63	F 689		

following actions:
a. On 4/4/23 at 12:45 PM one on one training with the Maintenance Director and Maintenance Technician. Additional education provided to the current employees regarding communication and the process of the door watch when the door alarms are shut off for repair and who needs communication with the plan to provide on-going .
b. On 4/4/2023 at 12:45 PM the staff in all departments received reeducation on communication, properly preparing for the door alarms to be shut off, the Door Alarm policy and procedure prior to returning to work assignment. The facility planned to provide ongoing training.
c. On 4/4/23 at 9:30 AM the facility completed a walk-through of the building to ensure properly functioning alarms and no obstruction of the doorways.
d. On 4/4/2023 at 9:00 AM the facility completed a resident headcount after turning the door alarms back on.
e. On 4/4/23 at 1:30 PM the facility notified the Medical Director and reviewed it through the Quality Assurance Program Improvement (QAPI).
F. On 4/4/23 at 1:30 PM the Interdisciplinary team re-educated about the root cause of communication, proper preparation for when shutting off the door alarms, and reeducation on the procedure. The facility planned to provide on-going training.
G. The Administrator or designee would walk the facility and inspect exit doors Monday through Friday five times a week for two weeks, then twice a week for two weeks, and then randomly thereafter.
h. The facility would take the information to the monthly QAPI meeting for three months.
i. Management will be notified when alarms get shut off and management will ensure the doors

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 04/13/2023

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 689	Continued From page 64	F 689		

are continuously monitored until the alarms are back up.
j. The Administration staff will monitor the doors on weekends and off hours the charge nurse/supervisor will monitor the doors.
k. Management will walk rounds to ensure nothing is parked in doorways.

The scope lowered from a "K" to "D" at the time of the survey after ensuring the facility implemented education and their policy and procedures.

The facility identified a census of 53 residents.

Findings Include:

1. On 4/3/23 at 12:47 PM during entrance to the facility without entering a code to disable the door alarm observed no door alarm sounding. The Director of Nursing (DON) came to the door and revealed the doors are being worked on. She added that someone could not normally get into the facility that easily.

On 4/4/23 at 7:30 AM during entry into the building without entering a code to disable the alarm, observed no alarm sounding, or staff at the time.

On 4/4/23 at 7:41 AM observed the 100 hallway doors opened, during the exit into 800 wing without entering the alarm disable code, no alarm sounded, and no staff observed at the time.

On 4/4/23 at 7:43 AM witnessed at the end of 200 hallway a table and chair blocked the exit door. Able to walk around the table and chair and exit the building without entering the alarm disable

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 04/13/2023

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 689	Continued From page 65	F 689		

code no alarm sounded, and no staff observed at the time.

On 4/4/23 at 7:46 AM observed the end of the 300 hallway doors open, able to exit without entering the code to disable the alarm no alarm sounded. Remained in the 300 hallway for approximately 15 minutes total time and no staff were observed.

On 4/4/23 at 8:01 AM witnessed the front door open with no alarm sounding or staff.

On 4/4/23 at 8:03 AM observed the door at the end of the administrative hallway opened with no alarm sounding or staff observed.

On 4/4/23 at 8:20 AM watched Staff B, Dietary Aide, exit the 100 hallway doors without entering the alarm disable code or no alarms sounded. Staff B explained that the codes are off on the doors.

On 4/4/23 at 9:17 AM during a walkthrough of the facility with Staff E, Maintenance staff, to check the door alarms, Staff E explained that the 200 hallway has the door blocked with a table and chair to prevent residents from exiting the facility. Staff E revealed the doors haven't worked for a while and the facility is waiting on a company to come out and look at them. When tested, the door opened right away with an alarm sounding. During testing of the door alarms, a standing mechanical lift blocked the exit. Staff E added that the facility only had one main switch to turn off the door alarms in the facility. He explained that that morning the facility had the doors turned off as the maintenance staff worked on the floors. Staff E continued that when the facility turned off

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 04/13/2023

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 689	Continued From page 66	F 689		

the door alarms, the maintenance staff notified nursing staff. The nursing staff are to check the doors and residents every 15 minutes to make sure they are where they are supposed to be. Staff E continued to report that the maintenance staff notified the staff that they planned to turn off the door alarms prior to him turning them off.

On 4/4/23 at 10:32 AM Staff E explained that the facility could not turn off a specific door. He added that the facility tried that week before and it messed up the entire system.

On 4/4/23 at 10:36 AM Staff F, Registered Nurse (RN), reported that when the maintenance staff turns off the door alarms they will come and tell the staff. At that time the staff is to be on high alert with the residents.

On 4/4/23 at 10:41 AM Staff G, Certified Medication Aide (CMA), revealed when the maintenance staff turns off the door alarms they tell the staff and then they have someone watching the doors when there is a resident is at risk for elopement.

The Logbook Documentation related to Hazardous areas: door checks listed the doors passed each week. Staff E revealed they used to check them monthly but the facility now checks them on a weekly basis to ensure they are in working order.

The Routine Door Alarm Checks, Use of Door Alarm Logs policy dated April 2023 revealed that the staff should make routine door alarm checks to help maintain resident safety and well-being.

On 4/5/23 at 1:17 PM the Administrator reported

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 04/13/2023

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 689	Continued From page 67	F 689		

that she expected the staff to watch the doors when they got turned off.
2. Resident #17's Minimum Data Set (MDS) dated 1/3/23 identified a Brief Interview of Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS indicated that Resident #17 required extensive assistance from two staff with bed mobility, transfers, and toilet use.

Resident #17's Admission History and Physical dated 12/22/22 signed by a Physician's Assistant revealed:
1. Resident #17 fell at her home on 12/20/22 and had two other falls in the prior four days.
2. Resident #17's diagnoses included the following:
a. UTI (urinary tract infection)
b. Dementia
c. Possible NSTEMI (a type of heart attack)

Resident #17's Clinical Record lacked a fall risk assessment.

The Care Plan Focus dated 1/3/23 identified Resident #17 as a risk for falls. The Interventions directed the following:
a. Ensure Resident #17 has a call light within reach and encourage her to use it for assistance as needed. She needs prompt response to all of her requests for assistance.
b. Ensure a safe environment free of clutter and has adequate lighting. Clean up spills promptly.
c. Ensure proper footwear when out of bed.
d. Follow the facility's fall protocol.
e. Resident #17 needs a safe environment with: (SPECIFY: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at

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 04/13/2023

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 689	Continued From page 68	F 689		

night; Side rails as ordered, handrails on walls, personal items within reach). (unfinished intervention).
f. Initiate neurological checks per facility protocol for any or suspected head injuries.
g. Notify the physician and family of falls or injuries as needed.
h. Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat as ordered.

The Nurses Note on 1/12/23 at 7:29 AM identified that Resident #17 got up several times during the night, including self-transferring and walking out into the hallway with her walker. Resident #17 appeared confused and wanted to know where she was. She asked the question over and over again. She was transferred to her recliner, and then she tried to self-transfer out of that, and then transferred her into her wheelchair, and she wanted to go back to her recliner. Eventually the staff transferred her back into her wheelchair and she remained there the rest of the morning. The nurse noted that Resident #17 did not have a fever but intended to continue monitoring her.

The Daily Skilled Charting dated 1/15/23 at 9:02 AM listed that Resident #17 exhibited behaviors of yelling at staff, wandering, and spitting out her medications. The symptoms interfered with her care.

The Daily Skilled Charting dated 1/16/23 at 10:42 AM listed that Resident #17 exhibited behaviors of yelling at staff, wandering, and spitting out her medications. The symptoms interfered with her care.

The Daily Skilled Charting dated 1/17/23 at 12:28 PM listed that Resident #17 exhibited behaviors

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 04/13/2023

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 689	Continued From page 69	F 689		

of yelling at staff, wandering, and spitting out her medications. The symptoms interfered with her care.

The Nurses Note on 1/20/23 at 10:31 AM identified that Resident #17 had an injury of unknown origin as Physical Therapy noted a bruise to her head. The bruise appeared dark purple to light blue in color and measured 8 centimeters (cm) by (x) 6 cm. The note indicated that Resident #17 did attempt to transfer herself when left in her room alone. The staff assist Resident #17 with one person and a walker. The nurse notified the staff that Resident #17 needs to recline in the community living room by the nurses' station for closer monitoring and to not have the recliner remote within her reach. Resident #17 attempts to move the recliner up to try to self-transfer.

The Care Plan lacked information related to Resident #17 bruise her head, her attempts to self-transfer, her wandering, aggression, the amount of staff assistance needed to transfer, if left unattended she tries to get up alone, and that staff should have her in the recliner in the community living room to allow for monitoring.

The Nurse's Note on 1/25/23 at 6:20 AM revealed that the Certified Medication Aide (CMA) called a nurse to Resident #17's room at 5:18 AM due to (due to) her not responding. Upon entry to Resident #17's room discovered her lying on a mattress beside her bed on her stomach with her head turned to the right side. The CMA and Registered Nurse (RN) rolled Resident #17 onto her left side. Resident #17 appeared pale, cold to the touch with her lips and nail beds cyanotic (blue). The nurse could not get a blood pressure

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 04/13/2023

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 689	Continued From page 70	F 689		

(BP), an oxygen saturation (O2 sat), or a pulse. Resident #17 did have a respiratory rate of 6 with very shallow breathing. The nurse assessed her airway to ensure it did not have any blocking it, in which the nurse did not see anything visible. The nurse confirmed that Resident #17 had a do not resuscitate (DNR) code status. The CMA called 911 at 5:22 AM while the RN applied oxygen (O2) at 8 L (Liters) via a full-face mask. The CMA attempted to contact the Director of Nursing (DON) at 5:30 AM with no answer. The nurse made several unsuccessful attempts to obtain a complete set of vital signs (VS) and arouse Resident #17. Resident #17 remained on her left side until the Emergency Medical Technicians (EMTs) arrived. The CMA reported that she passed Resident #17's early morning (AM) medications about 10 minutes prior. At that time Resident #17 appeared awake, alert, and took her pills without incident. While the CMA gave another resident their pills, the CMA heard the resident call out so she went to check Resident #17. When she entered Resident #17's room she found her on the mattress beside her bed with her stomach down on the mattress and she had head facing left. The CMA turned Resident #17's head to the right and found her not responding so she called the RN to assess the situation. The EMTs transported Resident #17 out of facility (OOF) at 5:42 AM to the emergency room (ER). The nurse called Resident #17's emergency contact at 5:45 AM and reported that Resident #17 became unresponsive, so they sent her to the ER. The nurse paged the physician at 5:47 AM and again at 6:09 AM. The facility received a call from the ER nurse at 6:11 AM that Resident #17 passed away on her way to the ER. The nurse sent a text message and called the DON to notify her.

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 04/13/2023

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 689	Continued From page 71	F 689		

Resident #17's Certificate of Death revealed that she died 1/25/23 at 5:45 AM with a cause of death listed as atherosclerotic cardiovascular disease and the manner of death as natural.

The Falls and Fall Risk, Managing policy reviewed April 2023 instructed the following:
a. Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.
b. The interdisciplinary team will attempt to identify appropriate interventions to reduce the risk of falls.

On 4/13/23 at 1:28 PM, the DON reported that Resident #17 had adequate supervision and interventions to prevent falls.

3. Resident #4's Minimum Data Set (MDS) assessment dated 2/16/23 identified a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. The MDS included diagnoses of Parkinson's disease, pneumonia, non-Alzheimer's dementia, respiratory failure, and osteoarthritis. The MDS indicated that Resident #4 required extensive assistance from one person with transfers and toilet use.

The Fall Assessment dated 12/28/22 listed Resident #4 as a risk for falls.

The Care Plan Focus revised 12/2/22 indicated that Resident #4 had a risk for falls or had fallen due to medical conditions of Parkinson's disease and did not comply with asking for assistance from staff. On 11/27/22, Resident #4 had a fall

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 04/13/2023

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 689	Continued From page 72	F 689		

with no injury. The Interventions directed the following
a. 7/1/21 - Ensure clear walkway paths in Resident #4's room.
b. 7/1/21 - Assess my falls risk at least quarterly and when declines in my condition are observed.
c. 10/8/21 - Wheelchair cushion placed in wheelchair to replace pillow that he used to use.
d. 11/2/21 - Activities of daily living (ADLs) that Resident #4 needed assistance with ambulation and toilet use.
e. 11/2/21 - Anticipate my needs.
f. 11/2/21 - Ensure adequate lighting in Resident #4's personal space.
g. 11/2/21 - Keep my urinal within my reach.
h. 11/2/21 - Make sure that all of Resident #4's personal items that he could want to use are within his reach and at his level.
i. f. 11/2/21 - Check on me often to assess my needs.
j. 11/23/21 - Placed non-skid strips next to bed.
k. 11/23/21 - Encourage Resident #4 to use appropriate footwear when transferring.
l. 12/2/22 - Educational reminder to call for assistance.
m. 12/16/21 - Urinalysis with culture and sensitivity due to increased confusion.
n. 12/22/21 - PT/OT to evaluate and treat per recommendations.
o. 1/11/22 - Offer and assist Resident #4 to the restroom frequently to minimize resident's attempts at self-transferring 1/11/22.
p. 1/21/22 - Bolsters to be placed along the edge of bed for border identification as Resident #4 allowed due to fall on 1/21/22.
q. 1/21/22 - Remind me to use my call light and ask for help when I need to use the toilet, or transfer due to fall on 1/21/22.
r. 2/4/22 - Staff are to assist Resident #4 to bed

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 04/13/2023

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 689	Continued From page 73	F 689		

by staff between 7:30 PM and 9:00 PM due to fall on 2/4/22.
s. 2/10/22 - Anti-Roll backs placed on his wheelchair on 2/9/22.
t. 2/10/22 - Take pedals off the wheelchair when someone is not pushing Resident #4 to minimize fall risk related to his falls on 2/3/22. Resident #4 refused this intervention.
u. 2/10/22 - Transfer Pole placed in Resident #4's room to help assist him if he attempts to self-transfer due to fall on 2/9/22.
v. 3/1/22 - Anti-Tippers placed on his wheelchair due to fall on 3/10/22.
w. 3/11/22 - The Certified Nurse Aide (CNA) assigned to Resident #4's hall is to assist him out of the dining room after dinner, then assist him with his needs, assist him to bed. Fall 3/10/22.
x. 3/17/22 - Alarmed floor mat to be placed next to Resident #17's bed. The alarm will not alarm in his room but will alarm in the hallway to alert staff that he may be attempting to self-transfer. Fall 3/17/22.
y. 4/5/22 - The nurse spoke with his primary care provider (PCP) to taper Resident #4's Trazodone (antidepressant).
z. 5/17/22 - Resident #4 to have one-on-one (1:1) activities three to five times a week. Notification provided to the Activity Director and instructed to document any kind of refusal due to fall on 5/15/22.
aa. 6/11/22 - Staff are to offer and assist Resident #4 to the restroom every two hours and as needed (PRN) due to fall on 6/11/22.

The Care Plan lacked any interventions related to falls after 6/11/22.

The Orders - Administration Note dated 11/27/22 at 1:51 AM directed to check placement and

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 04/13/2023

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 689	Continued From page 74	F 689		

function of Resident #4's floor alarm every shift. The note indicated that Resident #4 did not have a fall alarm available.

The Nurses Note dated 11/28/22 at 6:16 PM indicated the facility received a returned fax from Resident #4's PCP regarding a fall on 11/27/22 and order to notify if he seemed abnormal and monitor per facility protocols.

Resident #4's clinical record lacked documentation of a fall on 11/27/22.

The Orders - Administration Note directed to check placement and function of Resident #4's floor alarm every shift. The note indicated that Resident #4 did not have a fall alarm available or not working from 11/28/22 through 1/5/23. The note indicated that the DON knew that the alarm did not work on 12/11/22, 12/16/22 - 12/19/22, 12/22/22 - 12/24/22, 12/31/22, and 1/4/23.

Resident #4's Clinical Record lacked additional interventions put into place due to the alarm not being available or working.

The Nurses Note dated 1/5/23 at 7:20 PM indicated that staff heard a resident calling for help saying help Resident #4 is on the floor. Staff found Resident #4 on the floor wearing only a brief, laying on his back with blood oozing from his head and right hip. The nurse applied gauze, abdominal pad (Abd), and wrapped it around Resident #4's head. An assessment revealed Resident #4's vital signs as temperature 98.1, pulse 85, respirations 22, blood pressure (bp) 115/66, oxygen saturation (O2 sat) 94% on room air (RA). Resident #4 denied any pain and neurological (neuro) checks started. Resident #4

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 04/13/2023

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 689	Continued From page 75	F 689		

stated to get him off the floor. Resident #4 reported being okay and that he did not need to go to the hospital. He explained that he wanted to get over there and lost his balance. The nurse calmed Resident #4 down and notified his daughter, who requested to send him to the local hospital. The nurse called an ambulance, got a doctor's order to send Resident #4 to the emergency room (ER), and notified the Director of Nursing (DON).

Resident #4 lacked an Incident Report related to his fall in the Risk Management of the electronic health record (EHR).

The Emergency/Trauma Department record dated 1/5/23 signed by a physician revealed a diagnosis of an acute head injury due to a fall from ground level that resulted in a laceration (cut) of the scalp. The report indicated that Resident #4 had four staples that should be removed in five to seven days.

The Falls and Fall Risk, Managing policy reviewed April 2023 instructed that
a. Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling.
b. The interdisciplinary team will attempt to identify appropriate interventions to reduce the risk of falls.
c. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant.

On 4/13/23 at 1:28 PM, the DON reported that

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 04/13/2023

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 689	Continued From page 76 Resident #4 had adequate supervision and interventions to prevent falls, but he will self-transfer and refuse assistance.	F 689		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, record review and policy review the facility failed to have a Physician provide a resident physical assessment once every 30 days for the first 90 days after admission for 1 of 5 residents (Resident #2) reviewed for Physician Services. The facility reported a census of 53 residents. Findings include:	F 712		

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 04/13/2023

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 712	Continued From page 77	F 712		

Resident #2's Minimum Data Set (MDS) assessment dated 2/10/23 listed an admission date of 11/4/22 from an acute (short-term) hospital. The MDS identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #2 required extensive assistance of two persons with bed mobility, transfers, and toilet use. Resident #2 required total assistance of one person with baths. The MDS indicated that Resident #16 did not ambulate and required a wheelchair for locomotion. The MDS included diagnoses of hypertension (high blood pressure), viral hepatitis (liver infection), anxiety disorder, depression, and encephalopathy (swelling on the brain).

Resident #2's Minimum Data Set (MDS) assessment dated 11/4/23 listed an admission date of 11/4/22 from an acute (short-term) hospital.

Resident #2's Census record listed an admission date of 11/4/22.

Resident #2's Physician Office Visit form dated 11/7/22 indicated she had an initial comprehensive physical assessment completed by a Doctor of Medicine (MD).

Resident #2's After Visit Summary dated 1/6/23 identified that she saw the MD for an office visit. Resident #2's clinical record lacked documentation of her seeing a Physician after 11/7/22 until 1/6/22.

The Physician Visits policy revised October 2022 instructed that the Physician and Extender must make resident visits in accordance with

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 04/13/2023

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 712	Continued From page 78 applicable state and federal regulations. The policy further documented that the attending Physician must visit their patients at least once every thirty days for the first 90 days following the resident's admission, and then at least every sixty days thereafter. On 4/11/23 at 9:29 a.m. the Director of Nursing (DON) acknowledged and verified that Resident #2 did not have a Physician visit during the month of December 2022.	F 712		
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		

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 04/13/2023

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 725	Continued From page 79	F 725		

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 clinical record, facility records, facility policy, resident interview, and staff interview, the facility failed to answer call lights in a timely manner for 2 of 4 residents reviewed (Residents #2 and #25). The facility reported a census of 53 residents.

Findings include:

1. Resident #2's Minimum Data Set (MDS) assessment dated 2/10/23 listed an admission date of 11/4/22. The MDS identified a Brief Interview for Mental Status (BIMS) score of 12, indicating moderately impaired cognition. The MDS identified Resident #2 required extensive assistance of two persons with bed mobility, transfers, and toilet use. The MDS indicated that Resident #16 did not ambulate and required a wheelchair for locomotion. The MDS included diagnoses of monoplegia of lower limb affecting left nondominant side (paralysis of left lower limb), charcot's joint of left ankle and foot (nerve damage), left foot drop, and overactive bladder. The MDS listed Resident #2 as occasionally incontinent of urine and always incontinent of bowel.

On 4/10/23 at 3:36 PM Resident #2 reported that it can take as long as an hour for someone to answer her call light and that she tracks the time by using the clock in her room.

Resident #2's Census listed her room as 818.

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 04/13/2023

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 725	Continued From page 80	F 725		

The Primary Alarm Activations and Response Times report with a date range of 2/6/23 to 4/6/23 listed the following times the call light did not get answered in 15 minutes or less for room 818.
1. 2/7 at 2:07 PM bathroom call box (bath)- 2 hours 7 minutes
2. 2/7 at 5:15 PM bath - 1 hour 36 minutes
3. 2/21 at 8:58 PM bedside call box (bed) - 1 hour 32 minutes
4. 2/27 at 7:30 PM bed - 36 minutes
5. 2/28 at 8:09 PM bed - 33 minutes
6. 3/5 at 9:11 PM bed - 34 minutes
7. 3/8 at 8:10 PM bed - 1 hour 7 minutes
8. 3/10 at 9:42 PM bed - 20 minutes
9. 3/10 at 10:03 PM bed - 31 minutes
10. 3/14 at 7:30 PM bed - 37 minutes
11. 3/14 at 8:39 PM bed - 31 minutes
12. 3/17 at 6:22 AM bed - 56 minutes
13. 3/17 at 7:13 PM bed - 36 minutes
14. 3/18 at 6:49 AM bed - 1 hour 6 minutes
15. 3/18 at 7:39 AM bed - 44 minutes
16. 3/18 at 9:17 AM bed - 48 minutes
17. 3/18 at 1:56 PM bed - 42 minutes
18. 3/18 at 8:50 PM bed - 1 hour 30 minutes
19. 3/19 at 9:30 PM bed - 45 minutes
20. 3/19 at 10:56 AM bed- 1 hour 49 minutes
21. 3/19 at 3:49 PM bed- 36 minutes
22. 3/19 at 4:50 PM bed - 1 hour 35 minutes
23. 3/20 at 7:36 PM bed - 33 minutes
24. 3/21 at 12:56 PM bed - 38 minutes
25. 3/25 at 6:18 AM bed - 38 minutes
26. 3/26 at 6:46 PM bed - 36 minutes
27. 3/27 at 9:38 PM bed - 51 minutes
28. 3/27 at 10:59 PM bed - 32 minutes
29. 3/30 at 6:32 AM bed - 55 minutes
30. 3/31 at 7:27 PM bed - 38 minutes
31. 4/1 at 3:08 PM bed A - 47 minutes
32. 4/1 at 3:25 PM bed B - 41 minutes
33. 4/1 at 7:27 PM bed - 1 hour 9 minutes

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 04/13/2023

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 725	Continued From page 81	F 725		

34. 4/2 at 11:02 AM bed - 39 minutes
35. 4/2 at 8:52 PM bed - 1 hour 9 minutes
36. 4/4 at 7:46 PM bed - 1 hour

2. Resident #25's Minimum Data Set (MDS) assessment dated 1/10/23 listed an admission date of 1/5/23 and a room number of 816. The MDS identified a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS indicated that Resident #25 required extensive assistance from one person with bed mobility and required extensive assistance from two persons with transfers. The MDS included a diagnosis of nontraumatic subarachnoid hemorrhage (bleeding in the brain by a broken blood vessel).

On 4/11/23 at 10:59 AM Resident #25 reported that she used her call light at bedtime to get help getting her legs into bed. She explained that she watched the clock on her wall to track the length of time for her call light to be answered and reported that it sometimes takes 45 minutes.

The Primary Alarm Activations and Response Times report with a date range from 2/6/23 to 4/6/23 revealed the following information about dates the resident's call light was activated in 2023 and the length of response time:
1. 2/19 at 1:57 AM bed - 43 minutes
2. 3/1 at 9:57 AM bed - 19 minutes
3. 3/5 at 7:06 PM bed - 29 minutes
4. 3/8 at 7:42 PM bed - 28 minutes
5. 3/22 at 6:23 AM bed - 45 minutes
6. 3/24 at 6:15 PM bed - 23 minutes
7. 3/25 at 4:33 AM bed - 26 minutes
8. 3/28 at 8:51 PM bed - 31 minutes
9. 4/1 at 10:08 PM bed - 32 minutes
10. 4/2 at 6:49 PM bed - 51 minutes

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 04/13/2023

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 725	Continued From page 82 The Answering the Call Light policy reviewed May 2022 directed that 1. The purpose of the procedure is to respond to the resident's requests and needs. 2. Answer the resident's call as soon as possible. 3. If you have promised the resident you will return with an item or information, do so promptly. 4. If assistance is needed when you enter the room, summon help by using the call signal. On 4/13/23 at 1:28 PM, the Director of Nursing (DON) reported that she expected call lights to be answered within 10-15 minutes.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and	F 726		

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 04/13/2023

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 726	Continued From page 83	F 726		

implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, staff competency checklists, facility record review, staff, and a Certified Medication Aide (CMA) Program Coordinator interviews, the facility failed to ensure qualified staff to perform certain treatments for 1 of 1 resident reviewed (Resident #12). The facility allowed CMA's to perform dressing changes outside of their scope of practice. The facility reported a census of 53 residents.

Findings include:

Resident #12's Minimum Data Set (MDS) assessment dated 3/1/23 identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS included diagnoses of diabetes, cellulitis (skin infection), heart failure, sepsis (blood infection), cirrhosis of the liver, and pulmonary hypertension (high blood pressure affecting the lungs). The MDS indicated that Resident #12 required extensive assistance with transfers, bed mobility, dressing, toilet use, and personal hygiene.

The Advanced Wound and Hyperbaric Center progress notes dated 10/22/21 at 9:00 AM indicated the Plan as Resident #12 to discharge

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 04/13/2023

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 726	Continued From page 84	F 726		

from the Wound Care Center and to follow-up with her Primary Care Provider (PCP) as needed or for any other medical concerns. The Edema Control listed that Resident #12 wore a compreflex (velcro wraps used to control swelling or edema) for compression to her bilateral lower legs. Resident #12 worked with an Occupational Therapy (OT) Registered/Licensed (R/L) at the nursing home. The order directed to care at the home rehab/lymphedema continues with lymphedema pumps.

The Care Plan Focus revised 12/2/22 indicated that Resident #12 had a potential skin impairment to her skin's integrity due to edema and weeping from lymphedema. The Invention dated 4/17/22 directed for Occupational Therapy (OT) and Nursing to treat per orders.

The Handwritten Orders dated 12/23/22 written by the OT directed the staff to continue to check Resident #12's right lower extremity (RLE) each shift and left lower extremity (LLE) daily. Lotion could be applied to the LLE to help release dried skin. RLE check every shift, cleanse and change if dressing wet on the evening and nights. Day shift to cleanse and change daily. If Resident #12 complained of pain in one leg, using the compression pump on the leg that is not sore. Apply compreflex daily on thigh, calf, and foot as this provides long-term compression all day.

The Handwritten Orders dated 2/20/23 written by the OTR/L instructed that per doctor's orders (and if their orders do not state the exact same thing, then they need to get a new order).
a. Apply and use compression pumps daily.
b. Immediately after pumps are removed, compreflex must go on over the edemawear.

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 04/13/2023

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 726	Continued From page 85 i. Green stripe - thigh ii. Red stripe - calf iii. Yellow stripe - foot iv. Compreflex on thigh, calf, and foot. Please, Certified Nurse Aides (CNAs), CMAs, and Registered Nurses (RN) make sure the compreflex is applied immediately after the pumps. Obviously the legs fill with fluid without compression. Please follow these orders daily as it did not occur consistently. An additional note indicated that regardless of what the Medication Administration Record (MAR) states, the compreflex are not going on Resident #12 about 30-40% of the time that the OTR/L comes. Otherwise, they don't get on her until late in the day, hours without pumps, and by then the legs are full. Resident #12's February 2023 Treatment Administration Record (TAR) included documentation that RNs, Licensed Practical Nurses (LPN), and CMAs did her treatments to her lower legs. On 4/5/23 at 1:45 PM Staff L, CMA/Scheduler, reported that Resident #12 did not have any open areas to her legs when she worked the medication cart. Staff L added that the only treatment she did involved changing the ABD pad when it got full from Resident #12's leg weeping. She explained that she used a spray wound cleanser with the ABD pad change. In a follow-up interview on 4/6/23 at 1:47 PM, Staff L reported the drainage color as clear and that it drained fluid from the edema. When questioned if the ABD ever had yellow or green drainage, she replied that it might have once or twice. Staff L added that it might have had a bad	F 726		

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 04/13/2023

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 726	Continued From page 86	F 726		

smell. She said that due to it being a long time ago, she couldn't remember because she left doing the medication cart and became a scheduler instead.

On 4/5/23 at 2:30 PM, Staff U, CNA/CMA, stated that Resident #12 had an open area to the back of her right lower leg that looked like a blister. He explained that he thought staff could have done a better job of taking care of her wound. He reported that one weekend in early February another CMA cared for Resident #12 during the day. When he came in in the afternoon, the previous CMA reported that Resident #12 refused her dressing change that morning. He explained that he went to her room and asked her if anyone changed her dressing that morning. Resident #12 responded that she did not because reported being too busy. Staff U reported that sometimes Resident #12 did refuse her dressing changes.

In a follow-up interview on 4/6/23 at 2:50 PM Staff U, said her dressing did have some yellow and green watery drainage off and on. Staff U explained that it occurred more so before she went to the hospital. He added that her wound did smell bad, but he did not know if the smell came from her leg or her feet since he was down by her foot. He described her entire right lower leg as a dark red in color.

The Competency Checklist - Certified Nursing Assistant Review for the facility's CMA's included the following
a. Staff H's, CMA, form completed 7/27/21 indicated that she had previous training and experience with dry dressing changes.
b. Staff G's, CMA, form completed 1/12/22 listed "N/A" (not applicable) for doing dry dressing

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 04/13/2023

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 726	Continued From page 87 changes. c. Staff L's, CMA, form completed 1/12/22 listed "N/A" for doing dry dressing changes. d. Staff U's, CMA, form completed 1/13/22 indicated that he had previous training and experience with dry dressing changes. On 4/13/23 at 9:55 AM a local CMA Program Coordinator reported that CMA's did not have a scope of practice, but guidelines. She expressed that CMA's are not allowed to work with any type of dressings. On 4/13/23 at 1:10 PM the DON denied knowing that CMA's could not do dressing changes.	F 726		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's	F 803		

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 04/13/2023

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 803	Continued From page 88	F 803		

dietitian or other clinically qualified nutrition professional for nutritional adequacy; and

§483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.
This REQUIREMENT is not met as evidenced by:
Based on review of the planned menu, observations, and staff interviews facility staff failed to follow the planned menu for residents. The facility identified a census of 53 residents.

Findings include:

The facility's Week 4 menu identified the following items as part of the planned menu for the breakfast meal on 4/4/23:
Choice of juice
Choice of cereal
Sausage patty
Waffles with syrup
Milk

On 4/4/23 at 8:15 AM observed the breakfast meal and saw the staff serve the following:
Option of oatmeal, cold cereal, or fried eggs
Bacon or sausage
Toast
Beverages
The options lacked waffles with syrup.

The facility's Week 4 menu identified the following items as part of the planned menu for the lunch meal on 4/4/23:
Ritzy chicken divan casserole
Onion roasted potatoes
Tossed Salad with dressing
Marbled cherry pie cake

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 04/13/2023

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 803	Continued From page 89 Beverage On 4/4/23 at 11:41 AM observed the lunch meal served to the residents the following: Ritzy chicken divan casserole Cubed potatoes or mashed potatoes Tossed salad with dressing Pineapple The options lacked the marbled cherry pie cake. The facility's Week 4 menu identified the following items as part of the planned menu for the lunch meal on 4/5/23: Open faced hot pork sandwich Mashed potatoes Gravy Roasted lemon broccoli Sweet potato crisp Beverage On 4/5/23 at 12:21 PM observed the lunch meal and the staff serve the residents the following meal: Open faced hot pork sandwich Mashed potatoes Gravy Carrots Pears Beverages The options lacked roasted lemon broccoli or sweet potato crisp. On 4/4/23 at 12:32 PM Staff A, Cook, reported that when the menu contains items that are not available in the facility she has to make substitutions for the residents' meals. Staff A revealed the residents need to have meat but the rest she decides what to make when she does not have food items available.	F 803		

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 04/13/2023

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 803	Continued From page 90 The Menus policy revised October 2017 directed the following: a. Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board. b. Menus for regular and therapeutic diets are written at least 2 weeks in advance, are dated and posted in the kitchen for at least 1 week in advance. c. Deviations from posted menus are recorded including the reason for the substitution or deviation, then archived. On 4/4/23 at 12:41 PM the Dietary Manager (DM) explained that she expected to be notified when something is missing for the meal to be prepared. The DM further revealed the facility did not have a lot of items in stock to follow the menus and they made a lot of substitutions. The DM added that she ordered large quantities of items to stock the kitchen in order to follow the menus. On 4/12/23 at 3:43 PM the Dietitian expressed that if something needs to be changed on the menu the facility needs to run them through her as there is not anyone in the building that has the qualifications to make the changes. She did not know of any changes to the menu made in the last two weeks.	F 803		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		

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 04/13/2023

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 804	Continued From page 91 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, facility record review, resident, and staff interviews the facility failed to ensure proper temperatures for foods served to residents. The facility reported a census of 53 residents. Finding Include: On 4/3/23 at 12:51 PM during the initial walkthrough of the kitchen the Dietary Manager (DM) revealed the facility did not have any food temperature logs from January 2023, February 2023, March 2023, or April 2023. The DM reported that she could not find any records from the prior DM. On 4/4/23 at 7:47 AM Resident #26 expressed that she had cold eggs and sausage on 4/3/23 for breakfast. Resident #26 explained that happened quite frequently. She added that she eats in her room and would like to eat hot food. On 4/4/23 at 8:41 AM observed a glass of milk sitting on the top of the meal service cart without ice. Staff A, Cook, checked the temperature of the milk. The thermometer revealed a temperature of 52.2 degrees Fahrenheit (F). Staff B, Dietary Aide (DA), placed the milk onto the tray and placed it into the meal cart for service. The DM intervened after hearing the temperature of the milk. Staff B dumped the glass of milk out and poured a new glass of milk for the resident.	F 804		

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 04/13/2023

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 804	Continued From page 92	F 804		

The Resident Council Meeting Summaries revealed the following information:

a. 11/17/22 under new meeting concerns, compliments, and suggestions revealed food temperatures could be warmer. The residents reported the food as cold and the drinks as warm.

b. 12/19/22 under new meeting concerns, compliments, and suggestions indicated the residents thought the food temperatures could be a little warm yet, especially at breakfast and dinner.

c. 2/16/23 under new meeting concerns, compliments, and suggestions listed an improvement with the food temperatures yet they still could be a little warmer especially breakfast.

d. 3/9/23 under new meeting concerns, compliments, and suggestions indicated an improvement in the food temperatures, but breakfast could still be a bit warmer.

The Food Preparation and Service policy revised September 2022 directed the following:

a. Residents are provided with food and drink that is palatable, attractive, at a safe, and appetizing temperature.

b. "Danger Zone" means temperatures above 41 degrees F and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF).

c. Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause a foodborne illness outbreak if consumed.

d. The following internal cooking temperatures/times for specific foods must be

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 04/13/2023

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 804	Continued From page 93 reached to kill or sufficiently inactivate pathogenic microorganisms: a. Poultry and stuffed foods - 165°F for 15 seconds b. Ground meat, ground fish and eggs held for service - at least 155°F for 15 seconds c. Fish and other meats - 145°F for 15 seconds. d. Fresh, frozen or canned fruits/vegetables - 135°F. e. Foods cooked in a microwave - 165° in all parts of the food. It is critical to measure the food temperature at multiple sites and allow the food to stand covered for two (2) minutes after microwave heating. On 4/11/23 at 1:41 PM the Administrator reported that they let the former DM go. The facility felt the former DM destroyed documentation prior to that happening.	F 804		
F 808 SS=E	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy, the facility staff failed to properly prepare and serve pureed diets. The facility identified a census of 53 residents.	F 808		

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 04/13/2023

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 808	Continued From page 94	F 808		

Findings include:

On 4/4/23 at 11:43 AM Staff A, Cook, placed two servings of casserole into the robo coupe (food processor) and added milk into the mixture. Staff A blended until smooth, took the mixture, and placed into the serving pan. Staff A did not measure the amount of puree food prior to placing it into the service pan.

On 4/4/23 at 12:32 PM Staff A explained that she put two servings into the robo coupe and added milk. Staff A reported that she did not measure the end mixture but used the scoop size off the chart. Staff A added that she did not know the correct way to puree the food and measurements with the chart because she never got trained. The Dietary Manager expressed that education would be given right away for the proper way to complete the puree process.

On 4/5/23 at 11:54 AM Staff C, Dietary Aide (DA), added two servings of pears into the robo coupe. Staff C blended the pears until smooth but did know about the serving size. Staff C asked the DM for assistance and the DM referred to the menu. The menu directed to serve four ounces of pureed pears. Staff C measured the mixture into a four ounce scoop, filling the entire scoop. Staff C planned to blend more pears to make the four ounce serving of pears for puree. Staff D, Cook, intervened and educated the staff immediately on how to portion the puree mixtures.

The Diet Type Report dated 4/4/23 listed three residents who received a puree diet.

The Therapeutic Diets policy revised October

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 04/13/2023

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 808	Continued From page 95 2017 instructed the following: a. Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care in accordance with his or her goals and preferences. b. If a mechanically altered diet is ordered, the provider will specify the texture modification. On 4/5/23 at 1:45 PM the DM acknowledged that she received education on the proper puree process but would be getting more. Staff D has helped her learn and educate the other staff.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility policy the facility failed to ensure that open	F 812		

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 04/13/2023

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 812	Continued From page 96	F 812		

food got dated after opening, products got labeled after removing them from the original package, and provide a clean sanitary kitchen to prevent contamination of food. The facility identified a census of 53 residents.

Findings include:

1. An initial kitchen tour conducted on 4/3/23 at 12:51 PM of the freezer in the kitchen revealed an undated, unlabeled, open package of hash browns ready for service.

2. The kitchen refrigerator contained the following undated, opened, and not labeled ready for service:

a. Gallon of chocolate milk
b. Gallon of white milk
c. Poured drinks covered with no label or date
d. Thickened orange juice
e. Thickened water
f. Thickened water with an open date of 3/19
g. Towels sitting in the bottom of the fridge absorbing standing water. A saturated brown box of coffee from water at the bottom of the fridge. The water appeared yellow and an opaque (unable to see through) white color.
h. Tomato juice
i. Prune juice
j. Tomato wedges in a bag with onion noted to have a black fuzzy spot approximately the size of a dime.
k. A bag of brown looking shredded lettuce
l. An box of cream cheese
m. A jar of minced garlic
n. Gallon of apple cider vinaigrette
o. Bag of shredded cheese
p. Gallon of thousand island dressing
q. lite salad dressing

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 04/13/2023

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 812	Continued From page 97 r. Gallon of french dressing s. Small squeeze bottle of french dressing dated 3/7/23 t. Pears in a serving dishes uncovered without a label 3. On 4/3/23 at 1:32 PM observed the back hall freezer door open. Staff attempted to close the door and the door came back open. The door would not stay closed. The thermometer revealed a temperature of 48 degrees Fahrenheit (F) inside of the freezer. Inside the freezer a bag of strawberries felt soft to the touch. All of the shelves in the freezer had an inch of frost on them. The Dietary Manager (DA) read the thermometer and revealed the door did not stay closed and all of the food in the freezer will be thrown away. 4. Observation of the kitchen revealed the following: a. Under the coffee machine and juice machine had a dark brown thick syrup consistency puddle. B. The kitchen floor had brown foot prints with food debris and paper on the floor c. Handwashing sink revealed brown dried spots in the sink d. Two brownies sitting on the counter uncovered ready for service e. Stove top with food debris along edges and dried food debris down the sides of stove. f. Black food debris in the stove bottom approximately the size of a quarter g. Cabinet fronts covered with streaks and food debris h. Hinges of cabinets rusty with clean dishes stored inside	F 812		

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 04/13/2023

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 812	Continued From page 98 i. Food debris noted on cabinet shelves with clean dishes stored in j. Ice machine noted to have a build up of white debris around edges and sides of the ice machine. On the top of the opening the white debris appeared to have multiple pink and black spots. The inside of the ice machine looked to have pink and yellow spots along the ice cover with water dripping down on the inside into the ice. k. The dry storage floor appeared to have food debris on it. l. The walk-in cooler's floor appeared to have food debris on it. Interview with Staff C, Dietary Aide (DA), revealed the coffee machine leaks all the time. Staff C reported that she cleans the under the coffee machine several times a week and has leaked as long as she has been employed at the facility. 5. Observations of the inside of food storage cabinet revealed the following: a. Open packet of jelly b. White granulated debris on shelf with other food products stored c. An open undated brown gravy packet d. An open undated brown sugar e. An open undated jar of capers. i. The label instructs to refrigerate after opening 6. The stove's vent hood contained grease in the hood. The sticker on the hood revealed the next cleaning date as 11/13/22. The DM verified that would be the most current information. 7. Observation during the initial kitchen tour revealed Staff B, DA, washing dishes. Staff B filled a dishrack with soiled dishes and pushed	F 812		

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 04/13/2023

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 812	Continued From page 99	F 812		

the rack through the dishwasher. Without performing hand hygiene, Staff B pulled the clean dishes out of the dishwasher and pushed another rack of soiled dishes into the dishwasher. Staff B without performing hand hygiene picked up clean dishes and shook water off of the dishes and stacked them up and carried them to the steam table for usage at the next meal. Staff B returned to the dishwasher and filled another rack with soiled dishes. Staff B without performing hand hygiene pulled clean dishes out of the dishwasher and pushed soiled dishes into the dishwasher.

Interview with DM on initial kitchen tour revealed staff should wash their hands when going from soiled dishes to clean dishes, all items in the fridge should be dated, and thrown away if past their expiration date. She confirmed the facility had issues with cleanliness in the kitchen and she is working on them. The DM explained she just took over the role only a day ago. The DM further revealed the facility does not have any records of food temperatures from January 2023 until April 3, 2023.

8. On 4/4/23 at 8:20 AM witnessed Staff B push meal trays down the 100 hallway to the 800 hallway with two bowls of oatmeal on top of the food cart uncovered and a slice of toast on a plate uncovered.

9. On 4/4/23 at 8:41 AM observed a glass of milk sitting on the top of the meal service cart. Staff A, Cook, checked the temperature of the milk, revealing a temperature of 52.2 degrees Fahrenheit (F). Staff B placed the milk onto the tray and placed it into the meal cart for service. The DM intervened after hearing the temperature of the milk. Staff B dumped the glass of milk out

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 04/13/2023

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 812	Continued From page 100	F 812		

and poured a new glass of milk for the resident.

10. On 4/5/23 at 9:51 AM revealed the following:
a. Two open undated gallons of white milk in the fridge.
b. An open undated gallon of chocolate milk in the fridge with no open date
c. An open, undated package of lettuce.
d. An open, undated package of sliced turkey.
e. Under the coffee machine and juice machine had a dark brown thick syrup consistency puddle.
f. Towels sitting in the bottom of the fridge absorbing standing water. A saturated brown box of coffee from water at the bottom of the fridge. The water appeared yellow and an opaque (unable to see through) white color.

Interview with DM revealed she talked to Maintenance about the water in the bottom of the fridge and they have not gotten to it yet as they are working on other things in the kitchen as well.

Interview with the Maintenance Director on 4/5/23 revealed he knew about the water sitting in the bottom of the fridges. He planned to address it that day after completing the ice machine.

The Sanitation F812 policy revised October 2022 directed the following information:
a. The food service area shall be maintained in a clean and sanitary manner
b. Utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.

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 04/13/2023

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 812	Continued From page 101	F 812		

c. Food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical.

d. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions and facility policy.

e. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.

f. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.

The Food Preparation and Service policy revised September 2022 directed the following:

a. "Danger Zone" means temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) Foods held in the danger zone for more than 4 hours (if being prepared from ingredients at ambient temperature) or 6 hours (if cooked and cooled) may cause a foodborne illness outbreak if consumed.

b. "Food Service" means the processes involved in actively serving food to the resident. When actively serving residents in a dining room or outside a resident's room where trained staff are serving food/beverage choices directly from a mobile food cart or steam table, there is no need for food to be covered. However, food should be covered when traveling a distance (i.e., down a

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 04/13/2023

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 812	Continued From page 102 hallway, to a different unit or floor). c. Food preparation staff will adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. d. Food is covered during transportation and distribution to residents. Review of the facility policy titled Food Receiving and Storage with a revision date of July 2014 revealed the following: a. All foods stored in the refrigerator or freezer will be covered, labeled and dated b. Beverages must be dated when opened and discarded after 24 hours. On 4/11/23 at 1:41 PM the Administrator revealed the kitchen staff is working on things and really are trying to get better.	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		

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 04/13/2023

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 842	Continued From page 103 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

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 04/13/2023

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 842	Continued From page 104	F 842		

provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on clinical record, facility policy, and staff interviews, the facility failed to accurately document intravenous (IV) medication administration on the Medication Administration Record (MAR) for 1 of 5 residents reviewed (Resident #24). The facility failed to have nurses chart that they did dressing changes and Certified Medication Assistants (CMAs) did instead for 1 of 4 residents reviewed (Resident #1). The facility reported a census of 53 residents.

Findings include:

Resident #24's Minimum Data Set (MDS) assessment dated 3/13/23 identified a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included a diagnosis of infection/inflammation due to internal fixation of spine. The MDS listed that Resident #24 received IV medications in the 14-day lookback period.

The Physician Office Visit form dated 3/22/23 signed by a Physician's Assistant indicated that Resident #24 had a diagnosis of infection and inflammatory reaction due to internal fixation device of spine, subsequent encounter.

The Physician Transfer Order Report dated

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 04/13/2023

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 842	Continued From page 105	F 842		

3/8/23 signed by a physician included an order for cefazolin 1 gram (g)/10 milliliters (mLs) sterile water injection. Inject 10 mLs into the vein every 12 hours.

The Orders - Administration Note dated 3/19/23 at 2:43 PM written by Staff K, Licensed Practical Nurse (LPN), revealed that a Registered Nurse (RN) administered the IV medication.

Resident #24's March 2023 MAR revealed that Staff K charted that she administered the Resident #24's IV medication on 3/19/23.

Resident #24's April 2023 MAR indicated that Staff I, Licensed Practical Nurse (LPN), charted that she administered Resident #24's IV medication on 4/5/23 and 4/7/23.

The Employee Files for Staff I and Staff K lacked documentation of the IV Certification to indicate they completed the required IV medication training.

The Orders - Administration Note on 4/5/23 at 1:06 PM written by Staff I revealed that the Director of Nursing (DON) administered the IV medication.

The Orders - Administration Note on 4/7/23 at 1:30 PM written by Staff I revealed that a Registered Nurse (RN) administered the IV medication.

On 4/11/23 at 7:58 AM, Staff I reported that she charted an IV medication administration because the electronic health record sent a message that it did not get charted and it made her feel anxious. She talked with the DON about the

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 04/13/2023

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 842	Continued From page 106	F 842		

issue. The DON told Staff I that she could write a progress note that the RN gave the IV medication.

The Guidelines for Charting and Documentation policy with a last reviewed date of May 2022 lacked guidance regarding the documentation of medication administration from one nurse about another nurse giving the medication.

On 4/11/23 at 1:33 PM, the DON reported that she occasionally gets too busy to document the administration of the IV medication. When she administered the IV medication, she instructed the LPNs that they could chart on the MAR that the resident received their medications and then write a progress note to clarify who administered the IV medication.

2. Resident #1's MDS assessment dated 11/18/22 identified a BIMS score of 13, indicating no cognitive impairment. The MDS documented that she required extensive assistance from two persons for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS indicated she received an antibiotic for 4 out of the 7 days in the lookback period. The MDS included diagnoses of osteomyelitis (bone infection), diabetes mellitus, cellulitis (skin infection with swelling), obesity, right eye blindness, chronic obstructive pulmonary disease (COPD, chronic lung disease).

The Admission Summary dated 11/14/22 at 1:29 PM indicated that Resident #1 readmitted to the facility due to cellulitis in her left lower leg and right foot, an acute (short-term) urinary tract infection (UTI), elevated troponin (protein found in the muscle of the heart), and atrial fibrillation (abnormal pumping of the heart that causes 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 04/13/2023

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 842	Continued From page 107	F 842		

abnormal heart rate). Medication changes included: apixaban (blood thinner) 5 milligrams (mg) 1 tablet every 12 hours for 90 days, metoprolol tartrate (high blood pressure) 25 mg 1 tablet every 12 hours and daptomycin (antibiotic) 500 milligrams (mg) intravenously (IV) 4 mg/kilogram (kg) everyday for 28 days until 12/6/22.

The November 2022 Medication Administration Record (MAR) contained an order for daptomycin (antibiotic) 650 milligram (mg) intravenously (IV) one time a day for osteomyelitis of the foot, lower extremity cellulitis for 26 days. Staff K signed the order indicating Resident #1 received the medication on 11/19/22 and 11/20/22. The remaining days a Registered Nurse (RN) signed the order.

The December 2022 MAR contained the following order: daptomycin 650 mg IV one time a day for osteomyelitis of the foot, lower extremity cellulitis for 26 days. Staff K signed the order on 12/3/22 and Staff L, Certified Medication Aide (CMA), signed for 12/5/22 indicating they administered the IV medication.

On 4/6/23 at 2:14 PM Staff K reported that she did not administer Resident #1's IV antibiotic in November. When asked why her initials are on the order as being completed she stated it is common for staff to sign the MAR for the order if the RN did not sign. Staff K said when that happened she put a progress note in the computer stating what RN administered the medication.

On 4/11/23 at 1:30 PM the Assistant Director of Nursing (ADON) stated RNs are to administer IV

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 04/13/2023

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 842	Continued From page 108	F 842		

medications. When asked why LPNs signed the IV order as being completed she indicated if it is done by the RN and they forget to sign it out as completed, the LPNs will sign it off. They should not be doing that, the staff member who completed it should be signing it out.

On 4/11/23 at 6:39 PM Staff L stated if she signed out an order that a nurse should complete, she might have done it in an accident. If a nurse is busy she may have signed it out for them.

On 4/12/23 at 2:12 PM the Director of Nursing (DON) stated only RNs or IV certified LPNs can administer IV medications. She added that if an LPN has finished their IV portion of their RN program they can administer IV medications. She has asked her board about this but has not received an answer. It's her thought process that if the LPN is in RN school they have the education and training to complete the IV medications. When asked how she knew that if the LPN did not receive their RN license or degree, she did not say anything. She acknowledged that she administered Resident #1's IV medication and would ask other nurses to sign it off for her because she got busy. She would then have that nurse put in a progress note stating she had completed it. When asked why a CMA signed it out as being completed, she stated that should not happen and the staff member probably did it in error.

3. Resident #21's MDS assessment dated 3/28/23 identified a BIMS score of 8, indicating moderate cognitive impairment. The MDS indicated she required extensive assistance from one person for bed mobility, toilet use, personal hygiene, and extensive assistance of two persons

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 04/13/2023

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 842	Continued From page 109	F 842		

for transfers and dressing. The MDS indicated that she had a risk for developing pressure ulcers/injuries and had one stage one unhealed pressure ulcer/injury. The MDS listed that Resident #21 received treatments included pressure reducing devices on her chair and bed, turning/repositioning program, pressure ulcer/injury care, and applications of ointment/medications other than to her feet. The MDS included diagnoses of nontraumatic intracerebral hemorrhage (brain bleed), hypertension (high blood pressure), diabetes mellitus, malnutrition (lacking minerals or vitamins), obstructive hydrocephalus (fluid in the brain), chronic kidney disease and atrial fibrillation (the heart pumps out of normal causing an irregular heart rate).

The Care Plan Focus dated 3/24/23 indicated Resident #21 had an actual impairment to her skin integrity due to fragile skin resulting in a coccyx wound. The Interventions encouraged the staff to monitor and document the location, size, and treatment of the skin injury.

A Weekly Nursing Skin Assessment completed on 4/10/23 for her 3/23/23 admission documented a 0.1 centimeter (cm) x 0.1 cm pressure ulcer.

The area remained a 0.1 cm x 0.1 cm pressure sore to her coccyx on skin assessments completed on 4/3/23 and 4/10/23.

Resident #21's March 2023 and April 2023 MAR included the following order
a. Wash with soap and water, apply triad cream to the coccyx pressure injury wound three times a day and as needed. Utilize a blue stryker air

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 04/13/2023

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 842	Continued From page 110	F 842		

cushion while sitting in a chair. Resident #21 is to not sit in her chair for longer than one hour at a time without repositioning.
i. Staff M, CMA, signed the order as completed on 3/24
ii. Staff N, CMA, signed the order as completed on 3/25 and twice on 4/1.
iii. Staff O, CMA, signed the order as completed or held on 3/28, 3/29 (held), 3/31, 4/1 (held), and 4/2.

4. Resident #22's Minimum Data Set (MDS) assessment dated 3/20/23 identified a Brief Interview of Mental Status (BIMS) score of 14, intact cognition. The MDS indicated he required limited assistance from one person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS listed that Resident #22 did not have a risk for a pressure ulcer/injury. The MDS listed that Resident #22 had one stage one pressure ulcer and used a pressure reducing device in his chair and bed. Resident #22 had nutrition or hydration interventions to manage skin problems, pressure ulcer/injury care, and applications of ointment/medications other than to his feet. The MDS included diagnoses of pneumonia, anemia, diabetes mellitus, malnutrition, depression, bipolar disorder, respiratory failure, hemothorax, pleural effusion, and alcohol dependence.

The Care Plan revised 3/8/23 lacked any documentation of Resident #22's pressure ulcer(s) or interventions for staff to care for Resident #22's pressure ulcer.

An Admission Assessment dated 2/22/23 at 3:16 PM documented Resident #22 admitted to the facility from the hospital with a pressure ulcer to

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 04/13/2023

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 842	Continued From page 111	F 842		

his coccyx and to his left heel. The pressure ulcer to his coccyx measured 3 centimeters (cm) by (x) 2.9 cm x 0.3 cm, stage III and his left heel pressure ulcer measured 1 cm x 0 cm, stage 1.

The February 2023, March 2023, and April 2023 Treatment Administration Record (TAR) for Resident #22 had the following order with a start date 2/23/23: cleanse coccyx ulcer with normal saline, apply santyl, then allevyn sacral dressing, change daily one time a day.
a. Staff P, CMA, signed the MAR indicating that she completed the treatment on 2/24, 3/2, 3/17, 3/31.
b. Staff N, CMA, signed the MAR indicating that she completed the treatment on 3/4, 3/18, 3/25, 3/27, 4/2, and 4/3.

The March 2023 TAR and April 2023 Medication Administration Record (MAR) and TAR for Resident #22 had the following orders with a start date of
a. 2/23/23: apply small mepilex border dressing to bulla on left heel for protective purposes, off load with pillow. Change every 3 days.
i. Staff N signed the order indicating she completed the treatment on 3/4, 3/25.
ii. Staff L CMA on 3/10
iii. Staff P on 3/31.
b. 3/16/23: Apply triad hydrophilic wound paste to coccyx daily with dressing change.
i. Staff P signed the order indicating she completed the treatment on 3/17 and 3/31.
ii. Staff N signed the order indicating she completed the treatment on 3/18, 3/19, 3/25, 4/1, 4/2, and 4/3.

On 4/6/23 at 2:14 PM Staff K stated that CMAs can only do skin treatments if the wounds are

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 04/13/2023

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 842	Continued From page 112	F 842		

closed.

On 4/7/23 at 3:47 PM Staff N stated she will be in the room with the nurse completing the treatments/dressing and will sign the order off as being completed because she was in the room with the nurse. She will also sign off the orders if the nurse lets her know that it needs to be signed off.

On 4/11/23 at 12:33 PM Staff J, LPN, stated nurses are supposed to clean treatments and dressings for residents that have a pressure ulcer. When asked if CMAs can apply triad cream, she indicated if the resident does not have an open wound they can do the creams. If the wounds are open, the nurse has to do it. When asked if the CMAs can sign the MAR related to the nurse's orders, she indicated the nurse has to sign the orders, CMAs should not be doing that.

On 4/11/23 at 1:30 PM the ADON stated the CMAs should not be doing treatments or dressings if the resident's wounds are open. They can apply creams and powders if they are not open. If the area is open or a pressure wound, the CMAs are not supposed to provide treatments. When asked if she did Resident #22's treatments or dressing to his coccyx or heel she replied that she applies the triad cream but not the dressing.

On 4/11/23 at 5:47 PM Staff Q, CMA, stated if the skin areas are open she does not complete his treatment or dressings; that is for the nurse. Even if the nurse is present she will not do the treatment or dressings. When asked why she signed the orders, including treatments and dressing changes for wounds, she indicated she

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 04/13/2023

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 842	Continued From page 113 did not recall doing that. On 4/11/23 at 6:42 PM Staff P said she does not complete treatments or dressings to Resident #22's pressure wounds on his coccyx or heel; the nurses do that. When asked why she signed the orders as completed, she replied that she did not sign out anything that she did not do. On 4/12/23 at 2:12 PM the Director of Nursing stated CMAs can complete topical treatments because some are more of a protective order but an actual wound order would need to be completed by the nurse. The CMAs can do wound treatments if the area is a stage I sore. If the area is open CMAs can't do the treatment or dressing, but if closed and its protective measure then CMAs can do it. When asked if CMAs can sign off the orders as being completed if the nurse did the wound treatment she stated no, the nurse should be signing off the orders. When asked if CMAs could complete the following order: cleanse coccyx ulcer with normal saline, apply santyl, then allevyn sacral dressing, change daily one time a day, she indicated CMAs could not do that because it is open. When asked if CMAs could complete this order: apply small mepilex border dressing to bulla on left heel for protective purposes, off load with pillow. Change every 3 days. The DON replied yes, because it's not open. After being informed that during the observation of the area with the ADON the previous week the wound appeared open, she stated then no they could not complete that order. The last question to the DON asked if CMAs could apply triad hydrophilic wound paste to a coccyx daily with dressing change, she stated no.	F 842		
F 880 SS=D	Infection Prevention & Control	F 880		

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 04/13/2023

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 880	Continued From page 114 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880		

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 04/13/2023

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 880	Continued From page 115 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interview, and facility policy review the facility failed to perform hand hygiene while completing incontinent cares for 1 of 1 (#21) observed for incontinent cares. The facility reported a census of 53 residents. Findings include: Resident #21's Minimum Data Set (MDS)	F 880		

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 04/13/2023

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 880	Continued From page 116	F 880		

assessment dated 3/28/23 identified a Brief Interview for Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. The MDS indicated she required extensive assistance from one person for bed mobility, toilet use, personal hygiene, and extensive assistance of two persons for transfers and dressing. The MDS indicated that she had a risk for developing pressure ulcers/injuries and had one stage one unhealed pressure ulcer/injury. The MDS listed that Resident #21 received treatments included pressure reducing devices on her chair and bed, turning/repositioning program, pressure ulcer/injury care, and applications of ointment/medications other than to her feet. The MDS included diagnoses of nontraumatic intracerebral hemorrhage (brain bleed), hypertension (high blood pressure), diabetes mellitus, malnutrition (lacking minerals or vitamins), obstructive hydrocephalus (fluid in the brain), chronic kidney disease and atrial fibrillation (the heart pumps out of normal causing an irregular heart rate).

The Care Plan revised 4/4/23 for Resident #22 lacked documentation related to her activities of daily (ADLs) and how many staff should assist her.

On 4/6/23 at 9:40 AM Staff R, Certified Nursing Assistant (CNA), and Staff S, CNA, completed incontinent cares for Resident #21. With a gloved hand Staff R removed Resident #21's wet brief from her front side then used the bed control to raise the resident's bed. With her gloves still on, Staff R and Staff S removed Resident #21's wet pants. Without removing her gloves or completing hand hygiene, Staff R obtained adult wipes from the Resident #21's dresser and handed them to

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 04/13/2023

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 880	Continued From page 117	F 880		

Staff S. As Staff R continued to wear the same gloves she removed the dirty brief and wet pants, Staff S pulled wipes out of the package and laid them on Resident #21's bedding. The removal of the brief exposed a white paste on Resident #21's coccyx with stool incontinence. Once staff S completed incontinence care for Resident #21's buttocks, she removed the glove from her left-hand. Without completing hand hygiene to her left hand, Staff S obtained a clean brief with her left hand, placed it under Resident #21 and assisted her to roll with her right gloved hand and left bare hand. Staff R assisted Staff S with turning Resident #21 to her right side then performed perineal (peri) cares to her front side while Staff R wore the same gloves. Staff R cleansed Resident #21's peri-area using her right hand, put the wipe in her left hand then threw it away. Staff R then touched Resident #21 with her right hand and continued to cleanse her with Staff R's left hand. Wearing the same gloves, Staff R and Staff S pulled Resident #21 up in bed. After assisting Resident #21 in bed, Staff S touched her blanket, bed controller, wedges to place under her, her call light, and bedside table. Both staff members failed to perform hand hygiene in between dirty and clean tasks. Before exiting Resident #21's room, Staff R and Staff S washed their hands for the first time..

On 4/12/23 at 2:12 PM the Director of Nursing stated hand hygiene should be completed when staff enter the room, between cares and after cares are done.

The facility's Hand Washing/Hand Hygiene policy revised August 2014 encouraged the staff to follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other

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 04/13/2023

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 880	Continued From page 118 personnel, residents and visitors. Staff are instructed to use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: before and after direct contact with residents, after contact with a resident's intact skin, after contact with objects in the immediate vicinity of the residents, after removing gloves. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing health-associated infections.	F 880		

Countryside Health Care Center

Plan of Correction

Recertification/Focused Infection Control/Complaint Survey Conducted April 3-13, 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.

F550 Resident Rights

The facility does ensure that residents have a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

A. Residents #2 and #25 have their call lights answered timely to meet their needs.
B. Residents who have a 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 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

F609 Reporting of Alleged Violations

A. Resident #17 no longer resides at the facility.
B. Residents that experienced a fall and died have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Education provided to Administrator and DON by the Regional Director of Clinical Services related to the state/federal requirements of ensuring all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property, are reported per state/federal requirements.
D. The Regional Director of Clinical Services will review facility incidents weekly to ensure resident incidents are investigated and followed up on as required by state/federal regulations. These reviews will be completed monthly x3, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: ADM/DON/Designee

Compliance Date: 5/12/2023

Jackie Loghry Pirner
Administrator 5/19/2023

F610 Investigate/Prevent/Correct Alleged Violation

A. Resident #4 did have an incident report completed 1/5/23 and was included in the Electronic Medical Record. Resident #15 did have a strike out on 3/11/23 in the Electronic Medical Record due to him NOT experiencing a fall that day. Resident #15 did NOT have a strike out on 1/7/23 and there was an incident report completed that day and existed in the Electronic Medical Record.
B. Residents experiencing an incident have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Education provided to Administrator and DON by the Regional Director of Clinical Services related to requirements of fully investigating resident incidents. Education provided by the Director of Clinical Services for the Licensed Nursing Staff related to requirements of completing investigations of resident incidents.
D. The Regional Director of Clinical Services will review facility incidents weekly to ensure resident incidents are investigated and followed up on as required by state/federal regulations. These reviews will be completed monthly x3, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: ADM/DON/Designee

Compliance Date: 5/12/2023

F641 Accuracy of Assessment

The facility does ensure that resident assessments are encoded accurately transmitted according to CMS guidelines.

A. Resident #22's MDS assessment has been updated and resubmitted with corrections on 5/4/23.
B. Residents with inaccurate MDS assessments have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Education provided to MDS Coordinator by the Regional Reimbursement Manager regarding the importance of the accuracy of MDS Assessments.
D. The Regional Reimbursement Manager will review facility MDS assessments weekly to ensure accuracy. The reviews will be completed monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: Regional Reimbursement Manager/MDS Coordinator

Compliance Date: 5/26/2023

F655 Baseline Care Plan

The facility does develop and implement a baseline person-centered care plan within 48 hours with results shared with resident and resident representative prior to the development of the comprehensive care plan.

A. Resident #18 no longer resides at the facility.
B. Newly admitted residents without a baseline care plan have the potential to be affected by this alleged deficient practice although none were found to be affected.
C. Education provided to Licensed Nursing Staff by DON/Designee related to the requirement of completing a baseline care plan within 48 hours of admission.
D. The DON/Designee will review baseline care plans weekly to ensure accuracy. The reviews 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

F656 Develop/Implement Comprehensive Care Plan

The facility does develop and implement a baseline person-centered care plan to address antibiotic usage, anticoagulant usage, anti-anxiety medication usage, opioid medication usage, antidepressant medication usage and side effects to watch for in residents.

A. Resident #1 no longer resides in the facility. Resident #21, #22, and #2's comprehensive care plan has been updated and resubmitted with corrections on 5/17/23.
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. Education provided to MDS Coordinator by the Regional Reimbursement Manager regarding the importance of the accuracy of Comprehensive Care Plan.
D. The Regional Reimbursement Manager will review facility Comprehensive Care Plans weekly to ensure accuracy. The reviews will be completed monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: Regional Reimbursement Manager/MDS Coordinator

Compliance Date: 5/26/2023

F658 Services Provided Meet Professional Standards

The services provided or arranged by the facility meet professional standards of quality.

A. Resident #1 no longer resides at the facility.
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. Nursing staff were educated by the DON/Designee related to following physician orders.
D. The DON/Designee will review new admission/readmission physician orders weekly to ensure accuracy. The reviews will be completed monthly x2, and then routinely with results forwarded to QAPI for further review and recommendations.

Responsible Party: DON/Designee

Compliance Date: 5/26/2023

F677 ADL Care Provided for Dependent Residents

The facility does provide bathing assistance twice weekly and/or per resident preference according to residents' individualized needs.

A. Residents #2, #16, #20, and #4 experienced no harm and currently receive bathing assistance twice weekly and/or per resident preference.
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. Nursing staff were educated by the DON/Designee on bathing assistance twice weekly and/or per resident preference.
D. The DON/Designee will audit bathing assistance to be completed twice weekly and/or per resident preference daily x5, weekly x4, and monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: 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. Resident #12 no longer resides in facility. Resident #5's PCP was notified on 1/6/23 of rash and referral received for Dermatology appointment on 4/17/23. Resident was seen by PCP in facility on 1/10/23, 3/14/23, and 5/9/23 with corresponding treatment orders received.
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

F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer

The facility does ensure that the resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable.

A. Weekly skin assessments and related treatments and interventions are being completed and followed for Resident #21 and #22.
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. Nursing staff were educated by the DON/Designee on pressure ulcer prevention and treatment. As part of the Plan of Correction, we reached out to Gina Anderson at ganderson@telligen.com for additional education and resources regarding pressure ulcers.
D. The DON/Designee will audit compliance with pressure ulcer care and treatment 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

Abatement

What happened?

The facility failed to communicate and properly prepare for a door alarm shut off. The facility had obstruction at one of the exits.

How did it happen?

Upon notification of the door alarms by maintenance director being shut off nursing staff failed to do door watch. Chairs put at exit and not removed.

What system failed?

Communication failed when the door alarms are activated in the facility alerting staff of a door opening – when alarms were shut off the door watch needs to be completed. Process failure because staff did not monitor door. Process failure of exit being clear in case of an emergency.

What does the community need to change?

1) 1:1 training with Maintenance Director and Maintenance Tech, and current employees of communication and process of door watch when alarms are shut off for repair and who needs communication 4/4/2023 at 12:45pm & on-going.
2) Staff in all departments re-educated on communication and properly preparing for a door alarm shut off and the Door Alarm policy and procedure – prior to returning to work assignment on 4/4/2023 at 12:45pm & on-going.
3) A walk-thru of the facility was completed to ensure alarms are functioning properly and nothing is obstructing doorways on 4/4/2023 at 9:30am.
4) Resident head count completed after door alarms turned back on at 9am on 4/4/2023.
5) Medical Director notified and reviewed through ADHOC QAPI 4/4/23 at 1:30pm.
6) IDT team re-educated on root cause of communication and properly preparing for a door alarm shut off and re-educated on the procedure on 4/4/2023 at 1:30pm & on-going.
7) Administrator or designee will walk the facility and inspect exit doors M-F 5x/week for 2 weeks, and then twice a week for 2 weeks and then randomly there after.
8) Information taken to QAPI monthly x3 months.

Responsible Party: DON/Designee

Compliance Date: 5/12/2023

F712 Physician Visits-Frequency/Timeliness/Alt NPP

The facility does ensure that residents are seen by physicians at least once every 30 days for the first 90 days after admission and at least every 60 days thereafter.

A. Resident #2 is currently seen by a PCP according to state requirements.

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. Nursing administration has been educated by the Administrator on Physician Visits-Frequency/Timeliness/Alt NPP and has created a tracking system monitoring the physician visit schedule for all residents.
D. The DON/Designee will audit physicians' visits and signed orders 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

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 #2 and #25 have their call lights 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

F726 Competent Nursing Staff

The facility does ensure that professional qualified staff perform certain treatments in accordance with applicable State laws.

A. Resident #12 no longer resides in the facility.
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. Nursing staff were educated by the DON/Designee ensuring that professional qualified staff perform certain treatments in accordance with applicable State laws.
D. The DON/Designee will audit treatments 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: 5/26/2023

F803 Menus Meet Residents Nds/Prep in Adv/Followed

The facility does follow the menu provided by Martin Bros. after review and signature by the Registered Dietician.

A. All residents are currently receiving their food as noted each day on the menu.

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. Dietary staff were educated by the Certified Dietary Manager on following the menu to meet residents' needs, prep in advance and an audit tool has been created.

D. The Certified Dietary Manager/Designee will audit menus daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: Certified Dietary Manager/Designee

Compliance Date: 5/26/2023

F804 Nutritive Value/Appear, Palatable/Prefer Temp

The facility does hold hot food temperature high enough to ensure prevention of bacterial growth.

A. All residents are currently receiving their food at a preferred palatable temperature necessary to avoid pathogen bacterial growth.

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. Dietary staff were educated by the Certified Dietary Manager on nutritive value, appearance, palatable, food temps and an audit tool has been created.

D. The Certified Dietary Manager/Designee will audit food temps daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: Certified Dietary Manager/Designee

Compliance Date: 5/26/2023

F808 Therapeutic Diet Prescribed by Physician

The facility does ensure that residents are provided a therapeutic diet prescribed by the physician.

A. All residents are provided a therapeutic diet prescribed by the physician.

B. Residents requiring a therapeutic diet residing in the facility have the potential to be affected by this alleged deficient practice although none were found to be affected.

C. Dietary staff were educated by the Certified Dietary Manager on therapeutic diets and an audit tool has been created.

D. The Certified Dietary Manager/Designee will audit therapeutic diets daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: Certified Dietary Manager/Designee

Compliance Date: 5/26/2023

F812 Food Procurement, Store/Prepare/Serve-Sanitary

The facility does ensure that food is stored, prepared, distributed, and served in accordance with professional standards for food service safety.

A. The ice machine has been cleaned, sanitized, and outside residue was removed. The cabinets have been cleaned and sanitized. The oven has been cleaned. The kitchen floor has been swept and mopped thoroughly. Carts have been cleaned and sanitized. The kitchen has implemented a daily cleaning schedule.

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. Dietary staff were educated by the Certified Dietary Manager on hand hygiene, glove usage, kitchen sanitation, cleaning schedules, and an audit tool has been created.

D. The Certified Dietary Manager/Designee will audit proper dietary department hygienic protocols and food storage daily x5, weekly x4, monthly x2, and as needed with results forwarded to QAPI for further review and recommendations.

Responsible Party: Certified Dietary Manager/Designee

Compliance Date: 5/26/2023

F842 Resident Records – Identifiable Information

The facility does not release information that is resident-identifiable to the public. The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information expect to the extent the facility itself is permitted to do so.

A. Residents #24 and #1 no longer reside at the facility.

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. Nursing staff have been educated by DON/Designee on proper documentation in resident records.

E. D. The DON/Designee will randomly review proper documentation in resident records weekly for accuracy. The review of proper documentation 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

F880 Infection Prevention & Control

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

A. Resident #21 is cared for by staff and they perform proper hand hygiene during cares.

B. 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 infection control practice including proper hand hygiene during cares.
D. The DON/Designee will audit compliance with infection control practice during cares 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: 5/26/2023