STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345390	A. BUILDING _____ B. WING _____	C 03/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MANOR	**7700 US 158 EAST STOKESDALE, NC 27357**

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E 000	Initial Comments The facility is in compliance with the requirements of 42 CFR Part 483. Subpart B for Long Term Care Facilities (General Health Survey). Emergency Preparedness, Event ID # J1E411.	E 000		
F 655 SS=E	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. §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).	F 655		4/8/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/04/2019

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F 655	Continued From page 1 §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 record review and staff interviews, the facility failed to develop a baseline care plan within 48 hours of admission with measurable objectives and timetables to address the immediate needs of Pain Management and Urinary Catheter Care for 1 of 2 residents (Resident #253). Findings included: Resident #253 was admitted to the facility on 3/15/19. The resident's cumulative diagnoses included Discitis of lumbar region, Lumbar back pain, Bladder neck contracture and Acute urinary retention. The admission Minimum Data Set (MDS) assessment was in progress and had not been completed. Review of Resident #253's baseline care plan dated 3/18/19 revealed a care plan had been developed for Activities of Daily Living, Dehydration/Fluid Maintenance, Falls and Return	F 655	DF655- Baseline Care Plan The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain incompliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 655	Continued From page 2 to Community Referral. 1. Pain Management: A review of the physician orders dated 3/15/19 revealed the following: a. Norco (hydrocodone-acetaminophen) 10-325 mg (milligrams) 1 tablet every 4 hours as needed for pain b. Oxycodone 10 mg 1 tablet every 6 hours as need for pain c. Robaxin (Methocarbamol) 500 mg 1 tablet four times a day for muscle spasm d. Fentanyl patch 72-hour one patch transdermal (to skin) once every 3 days for pain e. Gabapentin 300 mg 1 capsule at bedtime for pain f. Diclofenac sodium 2 grams: place onto skin four times a day as needed for pain A review of the baseline care plan dated 3/18/19 revealed no mention of Pain Management. 2. Urinary Catheter Care: A review of the physician orders dated 3/15/19 revealed the following: a. Catheter care every shift b. Catheter to remain in place until Urology follow-up c. Record urinary catheter care output every shift A review of the baseline care plan dated 3/18/19 revealed no mention of Urinary Catheter care. During an interview with the MDS Coordinator on 3/27/19 at 11:16 AM, she stated that she completed the baseline care plan after a care	F 655	The facility failed to develop a baseline care plan within 48 hours of admission with measurable objectives and timetables to address the immediate needs of Pain Management and Urinary Catheter Care for 1 of 2 residents. On 3/27, the MDS Coordinator completed the comprehensive care plan to include catheter care and pain management. For the resident cited, pain management and catheter care were being treated from admission using MAR but failed to be addressed in baseline care plan. On 3/29, the Director of Nursing (DON) reviewed all baseline care plan for recent admissions (3 total) and no other residents were affected for the previous 14 day look back period. All other residents had received comprehensive care plans by this date. On 4/2, The Director of Nursing educated the MDS Coordinator and Nursing Supervisors regarding the development of a person-centered baseline care plan for each resident to include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASSAR, when applicable within 48 hours of admission. This education will also be included in the orientation of any new MDS and Nursing Supervisors. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; During 3/27 to 4/4, the DON will review all new admissions and develop each baseline care plan until the nursing staff are trained using the new Interim Care	

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F 655	Continued From page 3 plan meeting with Resident #253, Resident #253's family member, social worker and rehab director. The MDS Coordinator also indicated that the baseline care plan was expected to include activities of daily living, dehydration/fluid maintenance, falls and discharge home goals. The MDS Coordinator further stated that pain management and urinary catheter care did not need to be included in the baseline care plan. She stated it will be included in the Comprehensive Care Plan after the admission MDS is completed. An interview was conducted with the Director of Nursing on 3/27/19 at 2:12 PM. During the interview, she stated that she did not expect the baseline care plan to include pain management and urinary catheter care. The DON further stated that pain management was already covered on the Medication Administration Record. The DON also stated that urinary catheter care was a basic nursing skill that was expected of every nursing assistant. She further indicated the baseline care plan was enough as written. During an interview with the Administrator on 3/27/19 at 3:09 PM, he stated that he did not have the proper credentials to decide whether the baseline care plan should include pain management and urinary catheter care for Resident #253. After the administrator reviewed the regulation related to baseline care plan, he indicated he still did not have the credentials to say if either problem should or shouldn't be included on the baseline care plan, but that he did expect the baseline care plans to be completed according to the regulations.	F 655	Plan form. On 4/5, the DON will educate the MDS Coordinator, the Nursing Supervisors and all nurses on the accurate completion of this document to develop each baseline care plan within 48 hours of admission. This education will include adding catheter care and pain management to the plan when indicated for each resident. The facility will implement an Interim Care Plan for all new admissions that includes the initial goals stated previously. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing will conduct a review using the Care Plan Audit Tool that was developed for this deficiency. The DON will ensure accuracy in documentation for all new admissions for the next 4 weeks. The review will include initial goals based on admission orders, physician orders, dietary orders, therapy services, social services and PASSAR, when applicable within 48 hours of admission. Identified issues will be addressed with appropriate action. Reports will be presented to the QA committee by Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Medical Director, Director of Nursing, MDS Coordinator, Nursing Supervisors, Therapy, Health Information Manager (HIM), Administrator and other departmental managers.	

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F 880	Continued From page 4	F 880		
F 880 SS=D	Infection Prevention & Control 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;	F 880		4/8/19

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F 880	Continued From page 5 (iv)When and how isolation should be used for a 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 observation, interview and record review the facility failed to clean scissors used for treatment dressing and was applied to a stage 3 pressure ulcer for 1 of 1 (Resident #41) observed in pressure ulcer treatment. Findings included: Resident #41 was admitted to the facility on	F 880	DF880- Infection Prevention & Control The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain incompliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction	

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F 880	Continued From page 6 7/31/18 with a diagnosis of Heart failure, Dementia, Pressure ulcer and Major depressive disorder. Review of the treatment records indicated a treatment for the stage 3 pressure ulcer to right hip was revised on 3/15/19. The treatment order stated the right hip be cleaned with normal saline or wound cleanser. Then apply skin prep to around the wound and pack with calcium alginate dressing. Cover the wound with foam dressing and change the treatment three times a week. An observation for the dressing change was conducted on 3/26/19 at 3:09 PM. Nurse #1 got in the room of Resident #41 with all her treatment needs and placed it in a clean bedside table. She cleaned her hands with alcohol-based hand rub and donned a clean glove. Nurse #1 removed the old dressing and proceeded to clean the stage 3 wound with wound cleanser. After cleaning the wound, she applied the skin prep around the wound. She then picked up a whole pack of calcium alginate dressing and started looking for her scissors. She reached in with her gloved right hand to her right scrub pocket. It was observed that the nurse also picked up several pens and markers together with the scissors from her pocket. After she isolated the scissors, she used the scissors without cleaning to cut a small piece of the calcium alginate dressing and directly applied it to the stage 3 pressure sore. Nurse #1 then covered the wound with foam dressing. She was also observed putting the scissors back in her scrub pocket without cleaning. An interview with Nurse #1 at 3/26/19 at 3:15 PM right after the dressing change was conducted. Nurse #1 stated that she did not clean the	F 880	constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility failed to establish and maintain an infection prevention and control program by failing to clean scissors used for treatment dressing that was applied to a stage 3 pressure ulcer for 1 of 1 resident. For the resident cited, wound was monitored for signs/symptoms of infection and the resident was not harmed. The DON reviewed other treatments for residents and no others required scissors for treatments and were not harmed. On 3/27, DON educated the Nursing Supervisor as well as other nurses on proper cleaning and storage of scissors for wound care. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 4/2, the Director of Nursing (DON) reviewed policy and procedure for wound care. The policy was revised to include that each resident with a wound will be assigned individual scissors. The scissors	

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F 880	Continued From page 7 scissors before using to cut the dressing. Nurse #1 also stated she forgot to clean it after the treatment and before placing it back to her scrub pocket. She further stated that her scissors were clean and that she cleans it every couple of days. An interview with the Director of Nursing (DON) was conducted on 3/27/19 at 3:35 PM. The DON stated that she expected the nurse to clean the scissors before using it to cut the treatment dressing.	F 880	will be labeled with name, placed in treatment bags and located on treatment carts. Once wound has healed, the scissors will be disposed of properly. New scissors will be obtained with each new wound. On 4/2, The Director of Nursing educated all nursing staff regarding change in policy. This education will also be included in the orientation of any new nursing staff.	