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 04/18/2024

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

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/15/24 through 04/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 6CPR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/15/24 through 04/18/24. Event ID# 6CPR11. The following intakes were investigated NC00212070, NC00202013, NC00200743, and NC00215221. 2 of the 13 complaint allegations resulted in deficiency.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance	F 584		5/8/24

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

Electronically Signed | 05/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, residents and staff interviews, the facility failed to maintain walls in good repair for 2 of 2 rooms (Rooms 51 and 55) reviewed for environment. The findings included: 1a. An observation on 4/15/24 at 1:01 PM in Room 55 revealed multiple black marks and marring on the drywall next to Resident #32's bed. The drywall appeared to have been patched in an area that included the marred area, but not painted. A second observation was conducted on 4/18/24 at 10:10 AM in Room 55. The observation revealed the same black marks and marring next to Resident #32's bed. Some areas appeared to	F 584	F584 Safe/Clean/Comfortable/Homelike Environment The plan of correction is prepared and submitted solely because of requirements of state and federal law. 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	

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F 584	Continued From page 2 have been patched but not painted. 1b. An observation on 4/15/24 at 1:06 PM in Room 51 revealed the wall behind Resident #36's chair to have multiple black marks of various sizes and marring. A second observation of Room 51 on 4/17/24 at 10:09 AM revealed the wall behind Resident #36's chair to have black scuffs and marring at the top of the height of the chair. An interview with the Maintenance Director 4/18/24 01:20 PM revealed she had been the Maintenance Director since July 2023. She stated that staff, residents, and visitors were able to enter maintenance requests through an electronic kiosk in the hallway. These requests were reviewed by Maintenance several times a day. She stated she checks the system first thing each morning. The Maintenance Director further revealed staff could alert her to Maintenance concerns that required more immediate attention by stopping her in the facility. When completed, the request would be initialed by the Maintenance staff. A facility tour with the Maintenance Director occurred on 4/18/24 at 1:28 PM. She was not aware of the black marks and marring on the drywall in Rooms 51 and 55. The Maintenance Director had the expectation that other staff would have reported these concerns. She stated she completed regular rounding of rooms and safety rounds every month. An interview and facility tour with the Administrator on 4/18/24 at 1:33 PM revealed she was not aware of the marks and marring on the	F 584	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 maintain walls in good repair for 2 of 2 rooms (Rooms 51 and 55) reviewed for environment. After a review of the deficient practice, no residents were found to have been affected. The 2 rooms (Room 51 and 52) were repainted on 4/18/2024 to ensure the resident had a homelike environment with no black marks or marring of the walls. To identify any other residents having the potential to be affected by the same deficient practice, no other residents were seen to be affected at this time. After review of the deficient practice, an audit was performed in all rooms for needed repairs and painting. An audit was conducted by the facility Maintenance Director on 4/19/2024 through 4/25/2024. From the audit, 32 of 41 rooms needed to be touched up due to black marks and or marring of the walls. All 32 rooms have been completed with repairs and/or repainted before/or by	

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F 584	Continued From page 3 walls in Rooms 51 and 55. She stated that the marks were due to furniture and equipment against the walls. She stated that anyone can fill out a work request and staff would assist residents with the kiosk if needed. The Administrator revealed she and other management staff completed rounds and the safety committee met monthly to discuss concerns.	F 584	5/8/2024. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 5/2/2022, education was conducted by Administrator with all Department Heads, whom are a part of the Safety Committee at the facility to ensure the facility documents black scuffs, and/or marring of the walls onto their safety rounds monthly and/or as needed. The facility added to the Safety Committee Audit Document the environment free of black scoffs and/or marring of the walls. The Safety Committee Audit Document is completed monthly by the Department Heads and brought to the monthly Safety Committee Meeting. If black scoff marks and/or marring on the walls are found during the safety rounds, department heads will communicate to maintenance by inputting it onto our TELS maintenance log system. Maintenance will then complete the repairs. From 5/4/2024- 5/6/2024, education was provided with the Housekeeping and Maintenance Department by the Maintenance Director regarding what to look for when performing their deep cleans of rooms and how to notify Maintenance when there are findings of black scoffs and/or marring of the walls. In addition to, black scoffs and/or marring of the walls were added to the Deep Clean Checkoff List. The Deep Clean Checkoff list is completed by the Housekeeping	

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F 584	Continued From page 4	F 584	Department when conducting their deep clean schedules. If black scuffing's or marring of the walls are found, Housekeeping is to notify Maintenance through the TELS maintenance log system. On 5/2/2024, Administrator reviewed with QA team of weekly audits for black scuffing's and/or marring of the walls to ensure walls remain in good repair. Administrator reviewed education being conducted and adding the environment free of black scoffs and/or marring of the walls to the safety committee audit document as well as to the deep clean checkoff list. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. 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. On 5/2/2024, Administrator reviewed with QA team of weekly audits for black scuffing's and/or marring of the walls to ensure walls remain in good repair. Administrator reviewed education being conducted and adding the environment free of black scoffs and/or marring of the walls to the safety committee audit	

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F 584	Continued From page 5	F 584	document as well as to the deep clean checkoff list. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Weekly meetings between the Maintenance Director and Administrator will be held for the next 4 weeks and then once a month thereafter for the next 3 months. The weekly and monthly meeting will consist of the Maintenance Director and Administrator completing walk throughs of the facility and each resident room to ensure the facility maintains walls in good repair. Reports/Audits will be presented to the QA committee monthly by the Maintenance Director to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		

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F 689	Continued From page 6 §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 observation, record review, staff, Responsible Party (RP) and Nurse Practitioner (NP) interviews, the facility failed to prevent injury to a resident who sustained a laceration to his head when a corner shelf fell from the wall. This was for 1 of 2 residents reviewed for accidents. (Resident #55) The findings: Included: Resident #55 was admitted to the facility on 10/23/2019 with diagnosis that included hemiparesis following cerebral infarction affecting right dominant side, unspecified dementia, dysphagia. Review of Resident #55 quarterly Minimum Data Set (MDS) assessment dated 7/4/23 revealed the resident was severely cognitively impaired and was dependent on staff for Activities of Daily Living (ADL's.) Review of incident report completed by Nurse#1 dated 8/31/23 revealed nurse aide (NA)#1 and NA#2 were getting Resident#55 ready to perform care when a corner overhead shelf fell landing on the bed and right side of the residents' forehead/scalp. The report further revealed Resident #55 sustained a laceration above his right forehead. The wound measured 2(cm) centimeters by .02 is width to the top of the resident forehead. The laceration had a very	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 7	F 689		

small amount of bleeding, was cleansed, and steri- strips were applied. The report indicated Resident #55 remained at baseline for his neurological status and he was unable to voice pain due to his cognition during the assessment. The RP and Nurse practitioner (NP), Director of Nursing (DON) and Administrator were notified. Resident #55's overall status was monitored.

Review of facility summary of incident dated 8/31/23 revealed 2 NA's (NA#1 and NA#2) were preparing to perform morning care on Resident #55 when an overhead corner shelf fell from the wall and landed on the bed and hit Resident #55 in the frontal section of the forehead. One NA stayed with Resident #55 while the other went to retrieve a nurse. The nurse immediately entered the room to assist and ensure the resident was safe. The summary further revealed the DON and the facility Administrator were summoned to the room. Upon arrival the Administrator assisted with the removal of the shelving unit. The Administrator spoke with the aids about what happened. Next, the Administrator called for the Maintenace Director to come to the room to see if a conclusion could be made as to how or why the shelf fell. A definitive answer could not be made regarding how or why the shelf fell, and as a result the Administrator requested that all corner shelves be removed from residents' rooms to prevent further accidents and or injury.

Review of Nurses Progress Note dated 8/31/23 revealed around 9:40 am NAs were getting ready to perform care on Resident #55. The shelf over the head of bed (in corner to the right side of resident room) had fallen. The shelf (top part) was lying on resident with the top part of the shelf on Resident #55 forehead. The shelf was

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F 689	Continued From page 8	F 689		

removed, and Resident #55 had a laceration to the top of his forehead which measured 2 cm in length and 0.2 in width. The laceration was cleansed with Saline and patted dry, a Steri-Strip applied until bleeding stopped and antibiotic ointment applied. An ice pack was applied the first 20 minutes after incident. The forehead had no swelling and no drainage. The resident was alert and mumbling the whole time. The NP was notified as was the RP. No new orders were given and the NP stated to monitor vital signs (VS). If VS were out of range, and/or Resident #55 had a change in condition, send him out to Emergency Room. However, if Resident #55 VS remained stable do not send him out. Neuro Checks were initiated at 9:45 am and recorded onto a Neuro work sheet. Maintenance removed the shelf from Resident #55's room. Written by Nurse # 1.

Review of Medical Record 04/17/24 revealed Resident #55 revealed he was not on anticoagulant.

Review of Provider Progress Note dated 9/14/23 stated there were no new complaints. Resident #55 had recovered from the laceration. The assessment further stated his 2cm laceration on his forehead had well approximated edges and no surrounding erythema. Written by NP # 1.

Observation of Resident #55 room on 4/17/24 at 9:30 am revealed resident room did not contain any overhead shelves.

Interview with NA #1 on 4/17/24 at 10:00 am revealed the was in the room with Resident #55 preparing him for a shower on 8/31/23 and was awaiting assistance from NA #2 when the incident occurred. A corner shelf fell from the right corner

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of the room falling onto the bed and Resident #55. She stated the bed took most of the impact of the shelf falling, but it did hit Resident#55 on the top of his head. NA was unaware of what caused the shelf to fall off the wall. While NA #2 stayed with Resident #55. NA #1 went to get Nurse #1.

NA #2 was interviewed on 4/17/24 at 10:10 am. She was assisting NA #1 with Resident #55 preparing to transfer Resident #55 for bathing. As she entered the room the shelf came off the wall barely catching the top of Resident #55's head. NA #2 further stated that NA #1 left the room to get the nurse, and notify the DON, the Administrator. Nurse #1came into the room and did an assessment.

Multiple attempts were made to reach Nurse# 1 by phone. A message was left with no return phone call.

An interview with the NP was conducted on 4/17/24 at 10:30 am. The NP declined to answer questions regarding the event as she was longer responsible for residents in the facility. She further stated that the event happened so long ago she was fearful of providing inaccurate information.
An interview with the Director of Maintenance on 4/17/24 at 11:00 am revealed she recalled being summoned to Resident #55's room on 8/31/23 to determine how or why the shelf fell. She stated that no root cause could be identified and as a result, the Administrator requested that all corner shelves be removed from residents' rooms. The Maintenance Director stated no loose screws and no missing dry wall were observed.

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Resident #55's RP was interviewed on 4/17/23 at 1:30 pm. She stated she was notified by Nurse # 1 Resident #55 had sustained a laceration to the forehead after a shelf fell from the wall. She further stated by the time she arrived to the facility all the corner shelves had been removed from all resident rooms. The RP was unaware of how the shelf had fallen from the wall. Resident #55 did not have a scar and in her opinion did not suffer any ill effects from the incident.

An interview was conducted with the DON on 4/17/23 at 2:15 pm. She could not recall specifics of how she learned of the event, but recalled going to the room where the nurse was conducting a head-to-toe assessment of Resident #55. She stated the resident had a small laceration on the top of his forehead near the scalp. The DON continued by stating that she was unsure if a root cause was determined for the shelf falling, but it was decided that removing all corner shelves would prevent potential harm. The RP and NP were notified, and the resident was not sent to the hospital for further evaluation.

The Administrator was interviewed on 4/17/23 at 3:15 pm. She became aware of the incident regarding a shelf falling on Resident #55 during a daily morning meeting on 8/31/23 around 9:30 am. She stated that she and the DON reported to Resident #55 room and began to assist staff as needed. The Administrator stated that she assisted the nurse with removal of the shelving unit from the room. She further stated she began interviewing staff that witnessed the shelf fall and recalled summoning the Director of Maintenance to the room to assess the shelving. No root cause could be determined as to what or how the shelf came off the wall. To prevent injury to others the

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F 689	Continued From page 11 Administrator requested the removal of all corner shelves from resident rooms. The facility provided the following corrective action with a completion date of 09/4/23. The Administrator is the individual responsible for compliance with this action plan. 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 same deficient practice. " After a review, Resident # 55 was affected by the shelf falling from the wall. The resident was immediately assisted and assessed. Resident NP and POA notified. The Maintenance Director immediately was notified to assess the corner shelf. This was completed on 8/31/23. " After a thorough review, no other residents were affected at this time. To ensure all Resident safety, all corner shelves were removed in every room due to unknown cause of the shelf falling. This was completed on 8/31/23. " Due to unknown cause of the shelf falling, education was conducted to all staff by Administrator/Maintenance Director on reporting any equipment, outlets, furniture, shelving etc. that may be compromised and/or damaged to be reported immediately to maintenance and also put on maintenance order board. Address what measure will be put into place or systemic changes made to ensure what the deficient practice. " All corner shelves removed on 8/31/23. " Ad Hoc QA Meeting was held to review	F 689		

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F 689	Continued From page 12 incident on /8/31/23. " The QA committee consists of DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resources, Social Worker, Plant Operations Manager, and other department managers. " Maintenance Director assed the corner shelf to understand the cause of it falling. No known cause was made therefore the facility removed all corner shelves. " Due to uknown cause of the shelf falling, education was immediately started on 8/31/23-9/4/23 conducted to all staff by Administrator/Maintenance Director on reporting any equipment, outlets, furniture, shelving, etc. that may be compromised and or damaged to be reported immediately to maintenance and also put on maintenance order board. 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. " On 8/31/23, Administrator held an Ad hoc Quality Assurance Meeting. " Due to unknown cause, Education started in every department to review on reporting any equipment, outlets, furniture, shelving etc. that may be compromised and or damaged to be reported immediately to maintenance and also put on order board. " All corner shelves were removed on 8/31/23. " Due to removing all corner shelves, no monitoring or performance needed. " Corrective actions were implemented 8/31/23 to remove all corner shelves. All corner shelves were removed and completed 8/31/23. All education was conducted between 8/31/23-	F 689		

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 04/18/2024

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

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F 689	Continued From page 13 9/4/23. All corrective actions were completed on 9/4/23. On 4/18/2024 the facility's correction action plan was validated by the following: The facility provided documentation to support their corrective action plan including education provided to the Maintenance Director, and every department. The Maintenance Director audited and removed all corner shelving units in all resident rooms on 8/31/23. Observations were conducted of all residents' rooms and revealed no corner shelving. QAPI meetings were discussed with the Administrator and meeting notes were reviewed. There have been no further incidents accidents of falling objects onto residents. The facility's date of 9/4/23 for the corrective action plan was validated on 4/18/24.	F 689		