STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ___ B. WING ___	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on July 20, 2022 - July 21, 2022.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision based on assessed needs and in accordance with facility policy for 2 of 8 sampled residents (#6, #7) with a history of physical aggression (#6), and disruptive and socially inappropriate behaviors (#6, #7), resulting in two resident on resident altercations on 07/20/22 and 07/21/22, which resulted in a resident being sent to the emergency room for treatment of a facial injury (#6) and failure to provide increased supervision to the aggressive resident (#7) after the incident on 07/21/22. The findings are: Review of the facility's policy on Physical Aggression/Assault by a Resident, undated, revealed if physical aggression by a resident resulted in physical harm or a risk of death to another, the community would move the aggressive resident to another area within the	D 270		

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	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

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D 270	Continued From page 1 community to protect others. Review of the facility's policy on Incident/Accident Reporting, undated, revealed when a resident is at risk for death or physical harm may occur as a result of violence, the community would monitor the threatening resident to protect others from harm. A facility policy on Resident Supervision was requested on 07/21/22 at 10:45am and 07/21/22 at 1:25pm, and it was not received prior to exit. Review of Resident #6's current FL-2 dated 08/13/21 revealed: -Diagnoses included dementia without behavioral disturbances and physical deconditioning. -He was constantly disoriented and semi-ambulatory. Review of Resident #6's current care plan dated 04/20/22 revealed: -He had wandering behaviors. -He was verbally abusive. -He had disruptive behavior and was socially inappropriate. -He received mental health services. -He received medications for mental illness and behaviors. -He becomes aggressive at times when other residents enter room or get close to room but responds to redirection. -He was evaluated by his primary care provider (PCP) due to increased agitation and was started on new medication in February 2022 for agitation and anxiety. -He was disoriented to person, place and time. -He had significant memory loss and required redirection.	D 270		

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D 270	Continued From page 2	D 270		

Review of Resident #7's current FL-2 dated 09/13/21 revealed:
-Diagnoses included dementia with behavior disturbance.
-He was constantly disoriented, ambulatory and wandered.

Review of Resident #7's current care plan dated 04/20/22 revealed:
-The resident was injurious to self and others.
-He wandered and resisted care.
-He had disruptive behavior and was socially inappropriate.
-The resident would benefit from planned activities and monitoring.
-He was sometimes oriented and was forgetful and needed reminders.
-He received medications for mental illness and behaviors.
-He did not receive mental health services and a referral to a mental health provider had not been made.

1. Observation of Resident #6's doorway on 07/20/22 at 10:20am revealed Resident #7 was being pushed out into the hallway by Resident #6 and staff responded to Resident #6's room.

Observation of Resident #6 on 07/20/22 at 10:22am revealed:
-He was sitting on his bed in his room with a personal care aide (PCA) present.
-He was breathing heavy and was upset that another resident had entered his room.
-He complained and yelled that residents needed to stay out of his room.

Review of Resident #6's resident record on 07/20/22 revealed there was no progress note available documenting he pushed Resident #7.

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	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 3	D 270		

Review of Resident #7's resident record on 07/20/22 revealed there was no progress note available documenting he was pushed by Resident #6.

Interview with a personal care aide (PCA) on 07/20/22 at 10:24am revealed:
-Resident #6 was possessive of his room and would become angry and upset if another resident entered his room.
-Resident #6 was known for pushing other residents and yelling at them if they entered his room.
-Resident #6 was very protective of his personal space in his room.

Second interview with a PCA on 07/21/22 at 1:39pm revealed on 07/20/22 the medication aide (MA) asked her to stay with Resident #6 after he pushed Resident #7 out of his room.

Refer to the interview with a PCA on 07/21/22 at 1:40pm.

Refer to the interview with a MA on 07/21/22 at 12:30pm.

Refer to the interview with a second MA on 07/21/22 at 12:54pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/21/22 at 4:00pm.

Refer to the interview with the Health and Wellness Director on 07/21/22 at 4:35pm.

Refer to the telephone interview with the Administrator on 07/21/22 at 4:10pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 4	D 270		

Refer to the telephone interview with the facility's primary care provider (PCP) on 07/21/22 at 3:10pm.

Refer to the telephone interview with Resident #6's mental health provider on 07/21/22 at 2:40pm.

Based on observations, interviews and record reviews, it was determined that Resident #6 was not interviewable.

Based on observations, interviews and record reviews, it was determined that Resident #7 was not interviewable.

2. Observation of the facility hallway on 07/21/22 from 8:22am to 8:40am revealed:
-Resident #6 stumbled out of his room and walked towards the nurses' station with an injury to his left eye with blood running down his left eye from the injury at 8:22am.
-Resident #6 stated that Resident #7 punched him in the eye.
-Resident #7 came out of Resident #6's room and walked towards the nurses' station.
-At 8:25am, the medication aide (MA) took Resident #6 to his room to provide first aid.
-At 8:26am, the Health and Wellness Director (HWD) asked Resident #7 what happened in Resident #6's room and assessed his hands for any marks or injury.
-Resident #7 stated "he came out of nowhere".
-At 8:28am, the HWD instructed the Resident Care Coordinator (RCC) to send Resident #7 to the hospital for evaluation and treatment.

Observation of Resident #6 on 07/21/22 at 8:26am revealed:
-The MA directed Resident #6 to sit on his bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 5	D 270		

and provided first aid to his left eye.
-The MA applied pressure under his eyebrow to stop the bleeding from his left eye.

Review of Resident #6's facility progress note dated 07/21/22 at 3:21pm revealed:
-Resident #6 had a resident to resident altercation that morning (07/21/22) at 8:30am in his apartment.
-He had injuries to his right eye (observed by the survey team to be his left eye) including a small laceration and bruising by his right eyelid (observed by the survey team to be his left eye).
-Resident stated that when he went into his room and he found another resident laying in his bed.
-The Health and Wellness Director and Resident #6's POA were notified of the event at 8:45am.
-Resident #6's primary care provider (PCP) was notified of the event at 1:20pm.

Review of Resident #6's incident report dated 07/21/22 at 8:30am revealed:
-Resident said that another resident was in his bedroom on his bed.
-MA was notified by staff of an altercation between Resident #6 and another resident.
-Resident #6 was separated and wound care was provided.
-A 72 hour report was initiated for Resident #6.

Review of Resident #6's 72 hour report dated 07/21/22 revealed:
-The reason Resident #6 was on 72 hour monitoring was because of a resident to resident altercation.
-There were no concerns of abuse or neglect.
-There was no documentation in the section where it stated management was notified.
-The resident's vital signs were taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

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D 270	Continued From page 6	D 270		

Continued From page 6

Review of Resident #6's hospital discharge summary dated 07/21/22 revealed:
-He was seen at the emergency department for an alleged assault and an abrasion.
-He was diagnosed with injury due to altercation.
-He had a laceration to the left eyebrow ridge that was closing on its own and did not require repair.
-He was to be seen by his PCP within one week.

Review of Resident #7's incident report dated 07/21/22 at 8:30am revealed:
-Resident said that the other resident (Resident #6) startled him.
-The incident occurred in Resident #6's bedroom; there were no witnesses.
-The MA was at the medication cart and staff notified her that Resident #7 was startled by Resident #6 which caused the resident to resident altercation.
-Resident #7 was not injured in the resident to resident altercation.
-A 72 hour report was initiated for Resident #7.
-Staff attempted to redirect the resident away from other resident.
-The PCP, Health and Wellness Director (HWD) and family member were notified.

Review of Resident #7's 72 hour report dated 07/21/22 revealed:
-The reason Resident #7 was on 72 hour monitoring was because of a resident to resident altercation.
-There were no concerns of abuse or neglect.
-There was no documentation in the section where it stated management was notified.
-Resident #7's vital signs were documented on the 72 hour report.

Observation of Resident #7 on 07/21/22 from 8:26am to 8:46am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 7	D 270		

-He wandered down the 200 hallway without any staff monitoring him.
-He went into two resident rooms and interacted with two other residents.
-He walked around the outside of the living room.
-There was no staff supervision or immediate safety interventions put into place for Resident #7 immediately following his aggressive behavior with another resident.

Interview with a MA on 07/21/22 at 12:30pm revealed:
-If there was a resident to resident assault staff was to separate the residents.
-After Resident #7 assaulted Resident #6 this morning (07/21/22), staff should have taken Resident #7 to his room.
-She was not aware Resident #7 was not taken to his room because she was performing first aid to Resident #6 until the emergency medical services (EMS) arrived.

Interview with a second MA on 07/21/22 at 12:54pm revealed:
-The MA on duty was responsible for notifying other staff after a resident on resident assault to monitor and keep a "closer eye" on residents.
-She was not aware that Resident #7 did not receive any additional staff supervision or immediate safety interventions after the incident the morning of 07/21/22.

Interview with the HWD on 07/21/22 at 4:35pm revealed:
-She was not aware that staff did not monitor Resident #7 after the resident to resident assault.
-It was important for staff to immediately monitor Resident #7 to deescalate any additional aggressive behaviors.
-She expected staff to notify her of any resident to

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	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

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D 270	Continued From page 8	D 270		

resident assault.

Telephone interview with the Administrator on 07/21/22 at 4:10pm revealed:
-He expected staff to provide increased supervision and immediate safety interventions including increased monitoring after a resident to resident assault.
-He expected staff to monitoring residents involved in a resident to resident assault every 15 minutes to prevent further altercations immediately after the incident.

Telephone interview with the facility's mental health provider on 07/21/22 at 2:40pm revealed:
-She expected residents involved in a resident to resident assault to be monitored immediately after incident.
-It was important for the resident who was the aggressor in the incident to be monitored immediately so that staff can deescalate any further outbursts and prevent further injury to other residents.

Refer to the interview with a PCA on 07/21/22 at 1:40pm.

Refer to the interview with a MA on 07/21/22 at 12:30pm.

Refer to the interview with a second MA on 07/21/22 at 12:54pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 07/21/22 at 4:00pm.

Refer to the interview with the Health and Wellness Director on 07/21/22 at 4:35pm.

Refer to the telephone interview with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

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D 270	Continued From page 9	D 270		

Administrator on 07/21/22 at 4:10pm.

Refer to the telephone interview with the facility's primary care provider on 07/21/22 at 3:10pm.

Refer to the telephone interview with Resident #6's mental health provider on 07/21/22 at 2:40pm.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable.

Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.

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Interview with a PCA on 07/21/22 at 1:40pm revealed:
-All residents are to be checked on hourly during the day.
-There was no increased supervision for residents who had aggressive behaviors or known behaviors.
-She was trained that on night shift residents were to be rounded on every 2 hours.
-There was a spreadsheet that staff are responsible for indicating where each resident was hourly.
-Resident #6 was very possessive of his room and he was known to be aggressive with residents and staff.
-She was shocked that Resident #7 was violent with Resident #6 because she was not aware of any other times he was violent.
-Resident #7 was easily redirected.
-She was not aware of the incident when Resident #7 became violent with staff on July 14, 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

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D 270	Continued From page 10 Interview with a MA on 07/21/22 at 12:30pm revealed: -Safety rounds were completed on all the resident's hourly. -It was the responsibility of the PCAs to complete the hourly safety checks and document them on the spreadsheet indicating where they were at in the building. -The hourly safety check was where staff visualized the residents. -Resident #6 did not like germs and was very territorial of his room. -Resident #6 did not like other residents in his room and became verbally and physically aggressive when others were in his room. -Residents that were wanderers, verbally aggressive, and physically aggressive received the same amount of supervision as the rest of the residents with hourly rounding. -There was no increased supervision for residents with known behaviors. -If there was an incident such as a fall or resident assault, the MA would start the resident on 72 hour monitoring where it was documented in the communication hand off between shifts. -Staff received training on dementia residents during orientation with an online computer program. Interview with a second MA on 07/21/22 at 12:54pm revealed: -All residents received general supervision which included the hourly checklist where staff would document where the resident was in the building. -If there was a resident altercation, staff was to redirect the resident. -If a resident to resident assault occurs staff are to separate the residents, obtain vital signs, notify the resident's responsible party, notify the resident's provider, and notify management which	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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) COMPLETE DATE
D 270	Continued From page 11	D 270		

was the RCC or HWD.
-All resident assaults or aggressive behaviors should be documented in the progress notes.
-She was not sure why the event on 07/20/22 where Resident #6 pushed Resident #7 was not documented in the progress notes.
-There was not increased supervision other than the hourly safety checks that were completed on residents with known aggressive behaviors.

Interview with the Resident Care Coordinator (RCC) on 07/21/22 at 4:00pm revealed:
-She was not aware of the incident where Resident #6 pushed Resident #7 out of his room on the morning of 07/20/22.
-She would have expected staff to notify her and place the residents on the 72 hour report which would have alerted all staff to the altercation.
-All residents were monitored hourly but increasing supervision on residents that were aggressive to every 30 minutes might have prevented the situation where Resident #6 was injured and sent to the emergency room for treatment.

Interview with the Health and Wellness Director on 07/21/22 at 4:35pm revealed:
-She was not made aware of the incident on 07/20/22 in which Resident #6 pushed Resident #7 until after the incident occurred the morning of 07/21/22.
-Staff were expected to check on all residents every hour and to know their location.
-She expected the MA to contact the residents' PCP if there was a resident to resident altercation.

Telephone interview with the Administrator on 07/21/22 at 4:10pm revealed:
-He was surprised by Resident #7's aggressive

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COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

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D 270	Continued From page 12 behavior on 07/21/22 because he wasn't known to aggressive and was easily redirected. -He expected the PCP to be notified and the mental health provider when there was a resident to resident altercation. -He expected residents to be supervised every 15 minutes after a resident on resident assault for at least the 72 hour period that they were on the 72 hour report. -He expected increased supervision on the residents with aggressive behaviors to prevent further injury to residents or staff. Telephone interview with the facility's primary care provider on 07/21/22 at 3:10pm revealed: -She felt like residents at the facility were monitored closely including Resident #6 and Resident #7. -She had not been notified by the facility of the resident to resident altercations between Resident #6 and Resident #7. -If she had been notified that Resident #7 hit Resident #6, she would have made a referral for a mental health evaluation. -She was aware that Resident #6 was protective of his room and did not like other residents in his room. -Most of the residents in the facility had wandering behaviors. -Staff monitored residents closely and since the building was small it would be difficult for staff to not be able to see all residents. -She "guessed" increasing supervision of residents with aggressive behaviors would help prevent resident to resident assault. Telephone interview with Resident #6's mental health provider on 07/21/22 at 2:40pm revealed: -Resident #6 behaviors were hard to predict because his aggression escalates quickly.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

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D 270	Continued From page 13	D 270		

-Resident #6 was very possessive of his room and space.
-Resident #6 has known behaviors of becoming aggressive with other residents and staff when they are in his room or near his room.
-She expected residents with aggressive behaviors to be monitored more frequently than the other residents at the facility.
-She was concerned that if residents with known aggressive behaviors were not monitored more closely than the other residents that resident safety would be at risk.
-Increased supervisions of a resident who was known not to like other residents in or near his room and had a history of pushing other residents when they wandered near his room might have prevented resident harm.
-Resident #7 did not receive mental health services.
-The facility was expected to contact her if a resident needed a mental health referral evaluation.

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The facility failed to provide increased supervision for 2 residents with a known history of aggressive behaviors which resulted in one resident who was pushed (#7) by another resident (#6) on 07/20/22 and one resident who was sent to the emergency room (#6) after being hit in the eye by another resident (#7) on 07/21/22. The facility failed to provide increased supervision to the aggressive resident (#7) after the incident on 07/21/22 per their facility policy which placed additional residents at risk for injury. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

(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) COMPLETE DATE
D 270	Continued From page 14 CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 20, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews the facility failed to notify the provider of a resident's aggressive behavior towards staff (#7), a resident's aggressive behavior towards other residents (#6), and of a urine culture that was ordered but staff was unable to collect (#5). The findings are: 1. Review of Resident #7's current FL-2 dated 09/13/21 revealed: -Diagnoses included dementia with behavior disturbance. -He was constantly disoriented, ambulatory and wandered. -His recommended level of care was domiciliary rest home, secured memory care. Review of Resident #7's current care plan dated 04/20/22 revealed: -The resident was injurious to self and others. -He wandered and resisted care. -He had disruptive behavior and was socially inappropriate.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 15	D 273		

-The resident would benefit from planned activities and monitoring.
-He was sometimes oriented and was forgetful and needed reminders.
-He received medications for mental illness and behaviors.
-He did not receive mental health services and a referral to a mental health provider had not been made.

Review of Resident #7's electronic facility progress note dated 07/14/22 at 10:40pm revealed:
-A medication aide (MA) documented that Resident #7 had disruptive behavior and charged at her for no apparent reason.
-Resident #7 hit and swung at her and yelled he needed to get out.
-It took 4 additional staff to pull the resident off the MA.
-Staff attempted to redirect the resident and calm him down but were not successful.
-Staff contacted the Administrator by telephone to have him speak with the resident to calm him down.
-The resident was calm after talking with the Administrator on the phone.

Interview with a MA on 07/21/22 at 3:54pm revealed:
-She was hit several times by Resident #7 on 07/14/22 at 10:40pm.
-Resident #7 had a history of aggressive behaviors.
-She was surprised when the resident approached her and started yelling and swinging at her.
-She attempted to block the resident from hitting her but was unsuccessful.
-She was afraid because she was unable to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

(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) COMPLETE DATE
D 273	Continued From page 16 the resident to stop hitting her. -She did not notify the primary care provider (PCP) of the incident because she was so shaken up after the incident, she did not remember to call the PCP. Interview with the Resident Care Coordinator (RCC) on 07/21/22 at 4:07pm revealed: -The MA should have contacted the PCP to report Resident #7's aggressive behaviors. -She expected the PCP to be contacted when a resident was aggressive or had a change in behaviors. -MAs were expected to contact the Administrator, Health and Wellness Director (HWD), RCC, PCP and resident family member when an incident occurred. -She was not aware of the incident until she saw the electronic progress note earlier today (07/21/22). -She was concerned that the PCP had not been notified of Resident #7's aggressive behavior because he may have needed to be evaluated at the hospital. -Resident #7 should have been referred for an evaluation and services by a mental health provider. Interview with the HWD on 07/21/22 at 4:35pm revealed: -She was not aware that Resident #7 hit a staff member on 07/14/22. -Staff should have notified his PCP of his behavior. -Resident #7 could have benefited from a mental health evaluation and mental health services. Telephone interview with the Administrator on 07/21/22 at 4:37pm revealed: -He did not realize that Resident #7 was	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 17	D 273		

physically aggressive with the MA on 07/14/22.
-Staff told him that they were calling to have him help calm Resident #7 down because he was being aggressive.
-He did speak with Resident #7 by telephone on 07/14/22 and was able to calm him down.
-He did know that Resident #7 had not been referred to mental health services.
-The MA or HWD should have notified the PCP so that the referral could be made by the PCP to the mental health provider.
-Resident #7 would benefit from mental health services.
-The PCP should have been notified on Resident #7's aggressive behaviors on 07/14/22 so that any referrals could be made based on the PCP recommendations.
-He expected the MAs to notify the PCP, the family member, the Administrator, HWD and RCC whenever a resident had aggressive behaviors.

Telephone interview with Resident #7's primary care provider (PCP) on 07/21/22 at 3:10pm revealed:
-She was not aware that Resident #7 was physically aggressive with a MA on 07/14/22.
-She expected to be notified whenever a resident had inappropriate behaviors.
-She would have made a referral to mental health services if she had been notified of Resident #7's aggressive behaviors on 07/14/22.
-She would have expected the facility to provide increased supervision for Resident #7.

2. Review of Resident #6's current FL-2 dated 08/13/21 revealed:
-Diagnoses included dementia without behavioral disturbances and physical deconditioning.
-He was constantly disoriented and semi-ambulatory.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 18	D 273		

Continued From page 18

-His recommended level of care was a memory care unit.

Review of Resident #6's Resident Register dated 10/24/19 revealed he was admitted to the facility on 10/24/19.

Review of Resident #6's Special Care Unit Resident Profile completed 03/15/22 revealed:
-He was verbally abusive at times.
-He was physically abusive at times.
-He had paranoia and delusions.
-He had agitation.
-He was alert to person, place and time.
-He had short term memory loss.

Review of Resident #6's current care plan dated 04/20/22 revealed:
-He had wandering behaviors.
-He was verbally abusive.
-He had disruptive behavior and was socially inappropriate.
-He was receiving mental health services.
-He was receiving medications for mental illness and behaviors.
-He becomes aggressive at times when other residents enter room or get close to room but responds to redirection.
-He was evaluated by his primary care provider (PCP) due to increased agitation and was started on medication.
-He was disoriented to person, place and time.
-He had significant memory loss and required redirection.

Review of Resident #6's mental health provider note dated 04/18/22 revealed staff reported the resident had made much improvement in regards to his agitated behaviors and no medication changes were required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ____ B. WING ____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 19	D 273		

Review of Resident #6's mental health provider note dated 05/12/22 revealed:
-Staff reported no acute concerns at this time and no medication changes were required.
-The resident was to follow up in 1-3 months or earlier if clinically indicated.

Review of Resident #6's mental health provider note dated 06/16/22 revealed:
-Staff reported he became agitated with other residents and staff redirection.
-Medication changes were made to manage mood and compulsive type behavior.
-Staff was to monitor for risk of falls and other safety risks.
-Staff was to contact the mental health provider immediately for sedation, falls, or gait disturbances.

Observation of Resident #6's doorway on 07/20/22 at 10:20am revealed a resident was being pushed out into the hallway by Resident #6 and staff responded to Resident #6's room.

Observation of Resident #6 on 07/20/22 at 10:22am revealed:
-He was sitting on his bed in his room with a personal care aide (PCA) present.
-He was breathing heavy and was upset that another resident had entered his room.
-He complained and yelled that residents needed to stay out of his room.

Interview with a personal care aide (PCA) on 07/20/22 at 10:24am revealed:
-Resident #6 was possessive of his room and would become angry and upset if a resident entered his room.
-Resident #6 was known for pushing other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 20	D 273		

residents and yelling at them if they entered his room.
-Resident #6 was very protective of his personal space in his room.

Second interview with a PCA on 07/21/22 at 1:39pm revealed on 07/20/22 the medication aide (MA) asked her to stay with Resident #6 after he pushed another resident out of his room.

Review of Resident #6's facility progress notes revealed there was no documentation of the incident that occurred 07/20/22 when he pushed a resident out of his room.

Interview with the MA on 07/21/22 at 12:30pm revealed:
-She was instructed not to notify the provider unless injury occurred with resident to resident altercation.
-It was the MA's responsibility to notify the Resident Care Coordinator (RCC) if they were in the building of resident to resident assault so that she could notify the provider.

Interview with the RCC on 07/21/22 at 4:00pm revealed:
-She was not aware that Resident #6 pushed a resident out of his room on 07/20/22.
-She expected the MA to notify her and the provider of the resident's aggressive behavior.

Interview with the Health and Wellness Director (HWD) on 07/21/22 at 4:35pm revealed she expected the MA or RCC to notify the provider of any aggressive resident behavior towards staff or other residents whether there was any injury.

Telephone interview with the Administrator on 07/21/22 at 4:35pm revealed he expected the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 21 provider to be notified of all aggressive behaviors whether or not there was injury. Telephone interview with Resident #6's mental health provider on 07/21/22 at 2:40pm revealed: -She expected staff to notify her of any aggressive behavior by residents towards staff or other residents. -She was not aware of Resident #6 pushing another resident out of his room on 07/20/22. -If she was notified of Resident #6's aggressive behaviors on 07/20/22 she might have made medication changes or implemented additional interventions to address his behaviors and maintain the safety of the other residents. 3. Review of Resident #5's current FL-2 dated 07/18/22 revealed: -Diagnoses included Alzheimer's disease with late onset, hypertension, and hyperlipidemia. -She was ambulatory and constantly disoriented. -She was incontinent of bladder and bowel. Review of Resident #5's physician visit note dated 05/16/22 revealed: -Staff reported patient was sleeping more, taking several naps a day and sleeps all night. -Telephone conversation with Resident #5's family member revealed he was concerned about the resident's increased somnolence and that the resident was sleeping each visit they made to the facility. -The primary care provider (PCP) ordered a urinalysis with reflex to culture and sensitivity. Review of Resident #5's facility progress notes dated 05/17/22 at 6:32pm written by a medication aide (MA) revealed: -Staff attempted to get a urine sample but were not able to collect one on first shift.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

(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) COMPLETE DATE
D 273	Continued From page 22 -Staff were able to collect some urine on second shift but not enough to send for a sample. -There was no documentation of notification to the PCP that staff was not able to collect the urine sample. Review of Resident #5's facility progress notes dated 05/22/22 at 10:19am written by the Resident Care Coordinator (RCC) revealed: -Resident #5 was seen by the provider on 05/16/22 and a urinalysis with reflex to culture and sensitivity was ordered at the visit. -There was no documentation that the physician was notified that staff was not able to collect the urine sample. Interview with a MA on 07/21/22 at 12:30pm revealed: -MAs were responsible for collecting urine samples that were ordered. -The order for a urine sample would generate in the electronic charting system. -If staff was not able to obtain a urine sample that was ordered, they were to notify the Resident Care Coordinator (RCC) so that they could notify the PCP. -She was not aware if Resident #5's urine sample was collected that was ordered 05/16/22. -Resident #5 was continent of bladder and able to take herself to the bathroom. Interview with the RCC on 07/21/22 at 4:00pm revealed: -She was out of the office on vacation when the PCP ordered the urinalysis with reflex to culture and sensitivity on 05/16/22. -She was not notified by staff that they were not able to collect the urine sample. -If she was out of the facility, it was the MA's responsibility to notify the PCP that they were not	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

(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) COMPLETE DATE
D 273	Continued From page 23	D 273		

able to obtain a urine sample and document it in the electronic progress notes.

Interview with the Health and Wellness Director (HWD) on 07/21/22 at 4:35pm revealed:
-She expected staff to notify the PCP if there were not able to obtain a urine sample as ordered.
-It was the responsibility of the RCC or the MAs to notify the PCP and document it in the electronic progress notes.
-She was not aware that staff did not notify the PCP that they were not able to collect the urine sample that was ordered 05/16/22 for Resident #5.

Telephone interview with the Administrator on 07/21/22 at 4:10pm revealed he expected staff to notify the PCP if they were not able to obtain a urine sample on Resident #5 as ordered.

Telephone interview with Resident #5's PCP on 07/21/22 at 3:10pm revealed:
-She was not aware that staff did not collect the urinalysis and urine culture that was ordered on 05/16/22.
-She expected staff to notify her if they were unable to obtain a urine sample on Resident #5 as ordered.
-It was common that staff were not able to obtain urine samples in a population of residents with Alzheimer's disease and dementia.

Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable.

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The facility failed to notify the primary care provider (PCP) of Resident #7's aggressive behavior towards staff. The PCP would have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ____ B. WING ____	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 273	Continued From page 24 ordered additional interventions and treatments if they were aware of Resident #7's physical aggression. The facility also failed to notify Resident #6's mental health provider of an altercation with a resident on 07/20/22. The facility's failure placed the residents at a substantial risk of physical harm and constitutes a Type A2 Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/21/22. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 20, 2022.	D 273		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed residents taking their medications for 1 of 5 residents sampled (#1)	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

(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) COMPLETE DATE
D 366	Continued From page 25 leaving the medications unattended with a sleeping resident at the bedside in the Special Care Unit (SCU). The findings are: Review of the facility's undated Medication Administration Policy revealed: -Staff administering medication will stay with the resident until the medication is taken. -The nurse or tech who administered the medication would then document on the electronic medication administration record (eMAR) after giving the medication. Review of Resident #1's current FL-2 dated 04/25/22 revealed: -The resident's level of care was the special care unit (SCU). -Diagnoses included reactive hypothyroidism, hypertension, low platelets, reactive airway dysfunction, cough, and generalized weakness. -The resident was constantly disoriented and semi-ambulatory. -There was an order for Depakote 125mg(used to treat mood disorders) twice daily. -There was an order for Norvasc 2.5mg (used to lower and stabilize high blood pressure) daily. Review of a physician's order dated 05/23/22 revealed there was an order for Lasix 10mg (used to treat fluid retention) daily. Review of Resident #1's Care Plan dated 04/20/22 revealed: -The resident intermittently disoriented and had wandering behaviors. -The resident had limited strength in her upper extremities and required supervision with eating.	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	**5383 US 117 NORTH PIKEVILLE, NC 27863**

(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) COMPLETE DATE
D 366	Continued From page 26	D 366		

Observation of Resident #1's room on 07/20/22 at 10:19am revealed:
-Resident #1 was lying in bed asleep in her room with her back to the door and her dresser.
-The resident's roommate was not present in the room.
-There was no staff in the room or in view of the residents in the room from the doorway.
-There was a medication cup on the dresser directly next to the sleeping resident with one unidentified capsule, one unidentified half of a tablet, and one unidentified whole tablet which all appeared to be medication.
-There was a small cup of water next to the medication cup with pills in it.

Observation of resident room #104 on 07/20/22 at 10:27am revealed:
-Resident #1 was assigned to room #104 on the SCU and was asleep in her bed.
-Another resident was ambulatory and entered Resident #1's room.
-The other resident turned on the light switch located on the wall by a dresser.
-The other resident had a lollipop in her mouth when she entered the room.
-The other resident spoke to Resident #1 in her bed.
-The resident approached the dresser beside Resident #1's bed and placed her lollipop on top of the dresser to the right of the small plastic cup.
-The resident pointed to the small plastic cup with one unidentified capsule, one unidentified half of a tablet, and one unidentified whole tablet
-When the MA went to resident room #104, after she was alerted to the medication at the bedside by another surveyor, the MA redirected the other resident to leave Resident #1's room.

Review of Resident #1's July 2022 eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

(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) COMPLETE DATE
D 366	Continued From page 27 revealed: -There was an entry for Depakote 125mg twice daily. -The Depakote was documented as administered on 07/20/22 at 8:00am. -There was an entry for Norvasc 2.5mg daily. -The Norvasc was documented as administered on 07/20/22 at 8:00am. -There was an entry for Lasix 10mg daily. -The Lasix was documented as administered on 07/20/22 at 8:00am. Interview with the medication aide (MA) on 07/20/22 at 10:24am revealed: -She was the only medication aide that administered medication that morning (07/20/22) to all residents at the facility in the SCU. -She did not make sure Resident #1 swallowed her medications that morning before leaving the room and did not realize the resident still had them at the bedside. -It was the expectation and her responsibility to watch all residents swallow their medications prior to leaving the resident alone and document the administration after verification that the medication had been swallowed on the eMAR. -It was a medication error and a safety issue to leave medications at the bedside because the facility had residents with confusion and wandering behaviors that could come into the room and take medications that did not belong to them. Observation of the MA and the Special Care Coordinator (SCC) on 07/20/22 at 10:30am revealed: -The MA left the Resident #1's room with the medication left at the beside and reported the error of leaving Resident #1's medications at her bedside and that another resident wandered into	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE VILLAGE	5383 US 117 NORTH PIKEVILLE, NC 27863

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D 366	Continued From page 28	D 366		

Resident #1's room while the resident was asleep with the medications accessible on the dresser.
-The MA and the SCC walked to the medication cart and reviewed Resident #1's medication orders in the eMAR and compared the medication on had to the tablets and capsules in the medication cup left at Resident #1's bedside to verify the identity of the medications in the cup.
-The medication tablets and capsule were identified as Depakote (used to treat seizures and mood disturbances) 125mg (capsule), Norvasc (used to treat and lower high blood pressure) 2.5mg (whole tablet), and Lasix (used to treat and remove excess fluid retention) 10mg (half tablet) which were prescribed to Resident #1 and were to have been administered at 8:00am that morning.

Interview with the SCC on 07/20/22 at 10:35am revealed:
-It was her expectation of the MA to have ensured that Resident #1 swallowed her medications prior to exiting the room.
-It was unacceptable to leave medications at the bedside unattended because residents in the SCU were not oriented enough to take their medications independently and if they missed doses, they would not receive the treatment the medication was prescribed for.
-It was a safety issue to leave medications unattended at the bedside because there were residents who had confusion and wandering behaviors who might find the medications and mistake them for food or candy and ingest them which could cause adverse reactions.

Interview with the Health and Wellness Director (HWD) on 07/21/22 at 4:35pm revealed:
-Medications were expected to be administered by MAs by observing the resident swallow the

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D 366	Continued From page 29	D 366		

medications before leaving a resident's bedside and documenting on the eMAR accurately.
-In the SCU, many residents had confusion and wandering behaviors which was a safety concern that another resident could have taken medications that were not prescribed to them leading to harm and potential adverse health outcomes.
-MAs were trained to administer medications safely and finding medications unattended at the bedside was unacceptable because the MA knew better than to leave medications unattended.

Telephone interview with the Administrator on 07/21/22 at 4:09pm revealed:
-It was never acceptable to leave medications unattended at a resident's beside in the SCU.
-MAs were expected to ensure residents' swallow medications when administering medication prior to leaving a resident's bedside and documenting on the eMAR accurately.
-Having medications left unattended and within reach of resident's who were confused and may take the medications that were not prescribed to them was a safety issue due to the population of residents in the SCU who were confused and had wandering behaviors that could lead to adverse health outcomes.

Telephone interview with Resident #1's PCP on 07/21/22 at 3:12pm revealed:
-She expected MAs to ensure residents swallowed medications during administration and never leave medications unattended at the bedside.
-She expected the facility to store medications in a secure location and never leave them unattended.
-Residents in the SCU should never have unsupervised access to medications due to being

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D 366	Continued From page 30 confused and having wandering behaviors risking them taking medications not prescribed to them. -Lasix, Depakote, and Norvasc were medications that could be dangerous to residents that were not prescribed those medications due to potential side effects such as hypotension and allergic reactions which would require increased monitoring and a potential need for emergency medical evaluation or treatment. ________________________________ The facility failed to ensure a medication aide observed a resident take their medication for 1 of 5 sampled residents (#1). Resident #1, who was constantly disoriented, had her morning medications left at her bedside on the dresser by an MA which included a mood stabilizer, a diuretic, and a blood pressure medication, in which another SCU resident wandered into Resident #1's room and was observed to walk up to the medication cup full of Resident #1's medications. The facility's failure to ensure medications were swallowed and administered safely placed the residents at substantial risk of physical harm and neglect which constitutes a Type A2 Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/20/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED August 20, 2022.	D 366		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription	D 378		

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	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

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D 378	Continued From page 31	D 378		

medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure medications were locked up when not under the direct physical supervision of staff in charge of medication administration including the medication storage room.

The findings are:

Review of the facility's Medication Storage policy, undated, revealed accessibility to locked storage areas will only be by Licensed Nurse or medication aide (MA) responsible for medication administration, Executive Director or Director of Health Services.

Review of the facility's Receiving and Storing Drugs policy, dated 02/10, revealed the medication room and medication carts are to be locked at all times.

Review of the facility's current license effective January 1, 2022 revealed the facility was licensed for a capacity of 40 Special Care Unit (SCU) beds.

Review of the facility's resident census report dated 07/20/22 revealed there was a census of 32 residents.

Observation of the medication storage room on 07/20/22 from 10:00am to 10:23am revealed:

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D 378	Continued From page 32	D 378		

-There were no staff seated at the desk.
-The door to the medication storage room behind the desk was closed and unlocked.
-The storage cabinets in the medication storage room had locks on the cabinet doors but they were all unlocked.
-One of the cabinets in the medication storage room had 'house stock' medications which included multiple bottles of Tylenol (a medication used for pain relief), Colace (a stool softener), Aspirin, Vitamin B12, Vitamin D3, Zinc, 2- 16 ounce bottles of Milk of Magnesia (used to treat constipation), and 2 tubes of Arthritis Pain Relief cream.
-The medication refrigerator located in the medication storage room was unlocked and contained multiple vials of Arformoterol Tartrate inhalation solution (used to treat chronic obstructive pulmonary disease), a suppository used to treat hemorrhoids, and a vial of tuberculin purified protein derivative (PPD) injection.
-At 10:15am the Resident Care Coordinator (RCC) came to the desk.
-At 10:17am the RCC asked the medication aide (MA) on duty to bring the keys to the desk so that she could lock the cabinets in the medication storage room.
-At 10:19am both the RCC and MA went back down the hallway after locking the cabinets inside of the medication storage room that contained medications.
-At 10:19am the medication storage room door was closed but still unlocked.
-There was no staff present at the desk.
-At 10:20am, a resident with known wandering behaviors came up to the desk and threw away an applesauce container in a garbage can, behind the desk, next to the medication storage room door.
-At 10:23am the MA locked the medication

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	HAL096049	A. BUILDING: ______ B. WING ______	07/21/2022

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D 378	Continued From page 33	D 378		

storage room door.

Interview with a medication aide (MA) on 07/20/22 at 10:22am revealed:
-She thought that she had pulled the door to the medication storage room shut when she went down the hall with the RCC earlier that morning (07/20/22).
-The door was to remain locked to protect the residents from getting into the medication storage room.
-Only the MA and the RCC had access to the medication storage room.
-There were about 5 residents that wandered into other resident's rooms in the facility.
-The door does not automatically lock; you must turn the dial on the doorknob inside the medication room to lock the door.

Interview with a second MA on 07/20/22 at 10:26am revealed:
-She was not used to the medication storage room being unlocked because there was usually a staff member seated at the desk.
-She was aware that it was facility policy to keep the medication storage room locked but she had never seen any residents behind the desk before.
-The residents that they care for at the facility were sometimes forgetful and disoriented, so it was important to keep medications locked for their safety.

Interview with the RCC on 07/20/22 at 10:15am revealed:
-The medication storage room door should remain locked at all times.
-She was in and out of the room getting information from resident's charts earlier that morning.
-She was not sure if the cabinet doors inside the

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D 378	Continued From page 34	D 378		

medication storage room should be locked and who had a key.
-She was aware of 4 residents that wandered into other resident's rooms, but she has never observed a resident in the medication storage room.
-It was important for resident safety for the medication storage room to remain locked because the residents in the facility were confused and disoriented.

A second interview with the RCC on 07/21/22 at 4:00pm revealed she was not aware that the medication storage room was unlocked again this morning (07/21/22).

Interview with the Health and Wellness Director (HWD) on 07/21/22 at 4:35pm revealed:
-She expected the medication storage room to remain locked at all times when not in use.
-It was important with the resident population that they served that medications and medical supplies remaining locked in the storage room to keep residents safe.

Telephone interview with the Administrator on 07/21/22 at 4:10pm revealed he expected staff to follow the facility's policy and keep the medication storage room locked for resident safety.

Telephone interview with the facility's primary care provider (PCP) on 07/21/22 at 3:10pm revealed:
-She expected the medication storage room to remain locked for the resident's safety.
-She never observed a resident in the medication storage room while she was at the facility but there were known wanderers at the facility.

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D914	Continued From page 35	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free from mental and physical abuse, neglect, and exploitation and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision, Health Care, and Medication Administration. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision based on assessed needs and in accordance with facility policy for 2 of 8 sampled residents (#6, #7) with a history of physical aggression (#6), and disruptive and socially inappropriate behaviors (#6, #7), resulting in two resident on resident altercations on 07/20/22 and 07/21/22, which resulted in a resident being sent to the emergency room for treatment of a facial injury (#6) and failure to provide increased supervision to the aggressive resident (#7) after the incident on 07/21/22.. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)] 2. Based on observations, interviews, and record reviews the facility failed to notify the provider of a	D914		

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D914	Continued From page 36 resident's aggressive behavior towards staff (#7), a resident's aggressive behavior towards other residents (#6), and of a urine culture that was ordered but staff was unable to collect (#5). [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)] 3. Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed residents taking their medications for 1 of 5 residents sampled (#1) leaving the medications unattended with a sleeping resident at the bedside in the Special Care Unit (SCU). [Refer to Tag 366 10A NCAC 13F .1004(i) Medication Administration. (Type A2 Violation)]	D914		