-						NO. 0938-0391
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		DN	(X3) D.	ATE SURVEY DMPLETED
	345390	B. WING				C 04/25/2018
ROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE		
SIDE MANOR						
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EAC	CH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The fact implement a comprehe care plan for each reserves resident rights set fort §483.10(c)(3), that indo- objectives and timeframedical, nursing, and needs that are identified assessment. The com- describe the following (i) The services that a or maintain the resided physical, mental, and required under §483.24 (ii) Any services that a under §483.24, §483. provided due to the re- under §483.10, include treatment under §483.24 (iii) Any specialized services provide as a result of recommendations. If a findings of the PASAF rationale in the resided (iv)In consultation with resident's representat (A) The resident's pre- future discharge. Factor whether the resident's community was assess local contact agencies entities, for this purpor	ensive Care Plans cility must develop and tensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ed in the comprehensive nprehensive care plan must - ure to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse .10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the tive(s)- als for admission and deference and potential for ilities must document is desire to return to the seed and any referrals to is and/or other appropriate ise.	F 6	56			5/22/18
	-	2E		TITLE		(X6) DATE
	S FOR MEDICARE & I S FOR MEDICARE & I S DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCI REGULATORY OR L Develop/Implement C CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b) Comprehe §483.21(b)(1) The fac implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that ind objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.24 (ii) Any services that a or maintain the reside physical, mental, and required under §483.23 (iii) Any services that a or maintain the resider physical, mental, and required under §483.24 (ii) Any services that a or maintain the resider physical, mental, and required under §483.24 (ii) Any services that a or maintain the resider (iv) In consultation with resident's representat (A) The resident's goad desired outcomes. (B) The resident's pre- future discharge. Fac- whether the resident's pre- future discharge. Fac- whether the resident's pre- future discharge. Fac- whether the resident's pre- future discharge plans in	IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropria	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/ICLIA IDENTIFICATION NUMBER: (X2) MULTII A. BUILDIN 345390 B. WING CORRECTION 345390 B. WING B. WING CONDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC. DENTIFYING INFORMATION) ID PREFIX TAG Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) F 63 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's goals for admission and desired outcomes. (b) The resident's goals for admission and desired outcomes. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's desire to return to the communit	S FOR MEDICARE & MEDICAID SERVICES PF DEFICIENCIES PEDEFICIENCIES CORRECTION IDENTIFICATION NUMBER: JA5390 STREET ADDRES STOMER OR SUPPLIER STOMER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) TAG Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) \$483.21(b)(1) \$483.21(b)(2) \$483.21(b)(1) \$483.21(b)(2) \$483.21(b)(3) \$483.21(b)(1) \$483.22 \$483.22 \$483.23 \$483.21(b)(2) \$483.21(b)(2) \$483.21(b)(2) \$483.20(C)(2) <td>S FOR MEDICARE & MEDICAID SERVICES DF DEFICIENCIES (x1) PROVIDERSUPPLICALIA DENTIFICATION NUMBER: (x2) NULTIPLE CONSTRUCTION A BUILDING 346330 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE T700 US ISB EAST STOKESDALE, NC 27357 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PREFIX DEPROFEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b) (1) F 656 \$443.21(b) (1) F 656 S483.21(b) (3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (1) The services that would otherwise be required under \$483.10(c)(6). (ii) Any services that would otherwise be required under \$483.31(b) (c)(6). Impresent existing facility will provide as a result of PASARR recommendical services or specialized reationale in the resident's services of rights under \$483.10(c)(6). (iii) Any specialized services or specialized reationale in the resident's diverse treatment under \$483.10(c)(6). Impresential for admission and desired outcomes. (b) The resilty was assessed and any referrals to local contact agencies and/or other appropriate entities, for thy assesses and any referrals to local contact agencies and/or other appropriate entities, for</td> <td>S FOR MEDICARE & MEDICAID SERVICES OMB DP DEPICIENCIES (X) PROVIDENSEMPTERCUA IDENTIFICATION NUMBER (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) (C2) (C2) MULTIPLE CONSTRUCTION (C2) MULTIPLE CONSTRUCTIO</td>	S FOR MEDICARE & MEDICAID SERVICES DF DEFICIENCIES (x1) PROVIDERSUPPLICALIA DENTIFICATION NUMBER: (x2) NULTIPLE CONSTRUCTION A BUILDING 346330 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE T700 US ISB EAST STOKESDALE, NC 27357 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) PREFIX DEPROFEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b) (1) F 656 \$443.21(b) (1) F 656 S483.21(b) (3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (1) The services that would otherwise be required under \$483.10(c)(6). (ii) Any services that would otherwise be required under \$483.31(b) (c)(6). Impresent existing facility will provide as a result of PASARR recommendical services or specialized reationale in the resident's services of rights under \$483.10(c)(6). (iii) Any specialized services or specialized reationale in the resident's diverse treatment under \$483.10(c)(6). Impresential for admission and desired outcomes. (b) The resilty was assessed and any referrals to local contact agencies and/or other appropriate entities, for thy assesses and any referrals to local contact agencies and/or other appropriate entities, for	S FOR MEDICARE & MEDICAID SERVICES OMB DP DEPICIENCIES (X) PROVIDENSEMPTERCUA IDENTIFICATION NUMBER (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) (C2) MULTIPLE CONSTRUCTION A BULDING (C2) (C2) (C2) (C2) MULTIPLE CONSTRUCTION (C2) MULTIPLE CONSTRUCTIO

Electronically Signed

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

05/16/2018

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/25/2 FORM APPRO OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345390	B. WING		C 04/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
COUNTRYSIDE MANOR				7700 US 158 EAST	
				STOKESDALE, NC 27357	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 656	Continued From page	<u>م</u> 1	F 65	56	
		in accordance with the	100		
		h in paragraph (c) of this			
	section.	1 · · · · · · · · · · · · · · · · · · ·			
		is not met as evidenced			
	by:				
		iew and staff interviews, the		F656- Develop/Implement	
	-	e a care plan addressing the		Comprehensive Care Plan The statements made on t	
	•	ve diagnosis of depression		Correction are not an admi	
	(Resident #13).			not constitute an agreemer	
				alleged deficiencies. To ren	
	Findings included:			compliance with all Federa	
				Regulations the facility has	
		mitted to the facility on gnoses including dementia,		take the actions set forth ir Correction. The Plan of Co	
	anxiety and major de			constitutes the facility's alle	
				compliance such that all al	
	Resident's #13 Quart	erly Minimum Data Set		deficiencies cited have bee	-
		revealed the resident was		corrected by the date or da	
		mpaired. The resident was		The plan of correcting the	
	on an anti-anxiety, ar medication.	nti-depressant, and opioid		deficiency. The plan should processes that lead to the	
	medication.			cited;	denciency
	The resident had a ca	are plan last updated		The facility failed to create	a care plan
		her use of anti-anxiety		addressing the use of antic	-
	medications related t	o the diagnosis of anxiety		medication for 1 of 5 reside	ents (Resident
		It did not have a care plan in		#13) with an active diagnos	
	•	agnosis depression or use		On 4/25/18, the MDS Nurs	
	of antidepressant me			Resident #13's care plan to anti-depressant medication	
	Review of physician's	s orders for 4/2018 revealed		diagnosis.	
		ceiving 20 milligrams of		The procedure for impleme	enting the
		anti-depressant medication).		acceptable plan of correcti	
				specific deficiency cited;	
	A nursing note dated			On 5/09/18, the MDS Nurs	
		ntermittently throughout the		Supervisor and Director of	C
	shift.			reviewed all care plans for receiving anti-depressants	
	Nurse #2 was intervia	ewed on 4/25/18 at 12:35		diagnosis. All current resid	

Facility ID: 923121

If continuation sheet Page 2 of 10

		MEDICAID SERVICES				OMB NC	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDING	<u> </u>			c
		345390	B. WING			C 04/25/2018	
IAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE	04/	25/2010
NAME OF PROVIDER OR SUPPLIER					00 US 158 EAST		
					TOKESDALE, NC 27357		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETIO DATE
F 656	Continued From page	e 2	F 65	56			
	PM. She stated the re	esident cried a lot and the			5/13/18 with an order for antidepressar	nts	
	resident did not know	why. She stated the			and an active diagnosis were noted to		
	resident also had der	nentia and that the resident			have a care plan addressing the use of		
	was sad a lot.			antidepressants. As a result of the aud			
				there were no more identified residents	6		
	The MDS nurse was			needing care plan updates.			
	1:27 PM. She stated diagnosis of dementia			The MDS Nurse was educated by the Director of Nursing on 5/09/18 regardir	NG.		
		and anxiety. The res was			the development of a comprehensive	ig	
		lication for anxiety), Ativan			person-centered care plan for each		
		(a medication for anxiety), and Citalopram (a			resident to include measurable objectiv	/es	
	medication for depres	ssion). She stated the			and timeframes to meet a resident's		
	-	episodes of depression and			medical, nursing, and mental and		
		at she tried to update the			psychosocial needs that are identified i	in	
		ngs were added with the			the comprehensive assessment. The		
	-	uarterly MDS assessments.			comprehensive care plan must describ the following: services that are to be	e	
		w medication was added and			furnished to maintain the resident's		
		ate the care plan for it. On			highest practicable physical, mental, a	nd	
	the resident's last Ad	•			psychosocial wellbeing as required und		
	10/23/17, the residen	t only was on an anti-anxiety			483.24, 483.25 or 483.40. This would		
	and opioid medication	n. She stated the care plan			include the use of antidepressants for a	an	
		after the quarterly MDS was			active diagnosis. The care plan must b	е	
		are Area Assessment (CAA)			reviewed and revised by the		
		hission assessment, it stated			interdisciplinary team after each		
		depression and periods of e would have been the			assessment, including both the comprehensive and quarterly review		
		ve created the care plan for			assessments. This education will also	be	
	•	had wrote about it in the			included in the orientation of any new	~ ~	
		e was not a specific reason			MDS Nurses.		
	why her care plan did	-					
	anti-depressant medi	cation.			The monitoring procedure to ensure the		
					the plan of correction is effective and the		
		ng stated on 4/25/18 at 2:03			specific deficiency cited remains correct		
	-	was usually updated every			and/or in compliance with the regulator	У	
	admission assessme	plan was based on her nt_lf a resident bad a			requirements; The Director of Nursing and/or		
		they would update the care			Administrator will conduct a review usi	าต	
	onange in status the	andy would apadle the bare				·9	1

Facility ID: 923121

If continuation sheet Page 3 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /	G	. ,	MPLETED
						С
	345390				0	4/25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
COUNTRY	SIDE MANOR			7700 US 158 EAST STOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TH DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 656	Continued From page	e 3	F 65	56		
		ng stated on 4/25/18 at 2:40		to ensure the care plans and addressing the use a	antidepressants	
		d the resident's care plan nti-depressant medication.		and the active diagnosis The review will include a		
				care plans a week for 4 v		
				resident care plans a mo		
				Identified issues will be a appropriate action. Repo		
				presented to the QA com		
				Administrator and/or Dire	ector of Nursing to	
				ensure corrective action		
				ongoing concerns is initia appropriate. The QA Me		
				by the Director of Nursing	g, MDS	
				Coordinator, Unit Manag		
				Health Information Mana the Administrator.	ger (Hilvi), and	
				The title of the person re-		
				implementing the accept	able plan of	
				correction; Director of Nursing and/c	or Administrator	
				Date of Compliance: May		
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)		F 65	57		5/22/18
	§483.21(b) Compreh §483.21(b)(2) A com be-	ensive Care Plans prehensive care plan must				
		7 days after completion of ssessment.				
		terdisciplinary team, that				
	(A) The attending phy	ysician.				
	resident.	e with responsibility for the				
	resident.	responsibility for the				
	(D) A member of foor	d and nutrition services staff.	1	1		1

Facility ID: 923121

If continuation sheet Page 4 of 10

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULT	IPLE	CONSTRUCTION	OMB NO	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			COMPL	
						С	
		345390	B. WING			04/2	25/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	SIDE MANOR				700 US 158 EAST TOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 657	Continued From page	<u>م</u>	F 6	\$57			
1 007	-	ticable, the participation of	F 0	557			
		resident's representative(s).					
		be included in a resident's					
	medical record if the	participation of the resident					
		resentative is determined					
	not practicable for the resident's care plan.	e development of the					
		staff or professionals in					
		ined by the resident's needs					
	or as requested by th	-					
		ised by the interdisciplinary					
		ssment, including both the					
	comprehensive and c assessments.						
		is not met as evidenced					
	-	iew and staff interviews, the			F657- Care Plan Timing and Revision		
		e a care plan to reflect			The statements made on this Plan of		
	-	otion and transfer abilities of			Correction are not an admission to and	do	
	Living (Resident #49)	wed for Activities of Daily			not constitute an agreement with the alleged deficiencies. To remain in		
					compliance with all Federal and State		
	Findings included:				Regulations the facility has taken or wil	1	
					take the actions set forth in this Plan of		
		mitted to the facility on			Correction. The Plan of Correction		
		oses of muscle weakness,			constitutes the facility's allegation of		
	past joint replacemen	וו, מוש משנוווום.			compliance such that all alleged deficiencies cited have been or will be		
	Resident #49's Minim	num Data Set (MDS) dated			corrected by the date or dates indicated	d.	
	4/11/18 revealed the	resident was cognitively			The plan of correcting the specific		
		equired limited assistance			deficiency. The plan should address the	e	
	-	nsfers, walking in the room,			processes that lead to the deficiency		
		, and toilet use. The resident with personal hygiene. The			cited; The facility failed to update a care plan	to	
		tremities impairment on one			reflect the changes in locomotion and		
	side and used a whee				transfer abilities of 1 of 4 residents (Resident #14).		
		are plan, updated 4/15/18, in Daily Living (ADL's). The			The care plan for Resident #14 was not updated to address locomotion and	t	

Facility ID: 923121

If continuation sheet Page 5 of 10

				PLE CONSTRUCTION		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
			A. BUILDING	·	C	
		345390	B. WING			, 25/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
				7700 US 158 EAST		
COUNTRY	SIDE MANOR			STOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIO DATE
F 657	Continued From page	e 5	F 65	7		
1 007			F 00		aident #11 due to	
		that for locomotion and trequired 1 -2 person		transfer abilities on Res		
		se of a walker and gait belt.		The procedure for impl		
		set set and gut both		acceptable plan of corr		
	Nursing Assistant #1	was interviewed on 4/24/18		specific deficiency cited		
	at 10:52 AM. She sta	ted the resident was alert		On 5/10/18, the MDS N	lurse, RN	
	and oriented. The res			Supervisor and Directo	-	
		d walk to the bathroom and		reviewed all care plans		
	-	ng the walker and getting to		residents to ensure car		
	the bathroom.			accurate information re and transfer abilities. A		
	Nurse #1 was intervie	ewed on 4/24/18 at 11:07		updates to care plans v	2	
		Resident #49 was alert and		5/15/18.	vere completed by	
		on at times. She stated the		The MDS Nurse was e	ducated by the	
	resident was pretty m	nuch independent and could		Director of Nursing on	-	
	walk on her own in th	he hall and to the bathroom.		the development of a c	omprehensive	
				person-centered care p		
		served on 4/24/18 at 3:15		resident to include mea	-	
		s observed walking in the		and timeframes to mee		
	were noted.	th her walker. No concerns		medical, nursing, and r		
	were noted.			psychosocial needs that the comprehensive ass		
	Nurse #2 was intervie	ewed on 4/25/18 at 12:39		comprehensive care pl		
		the resident walked with her		the following: services		
	walker and could get	to the bathroom on her own.		furnished to maintain th		
		therapy had discharged the		highest practicable phy		
		s able to walk on her own.		psychosocial wellbeing	-	
	-	ait belt to help with walking		483.24, 483.25 or 483.		
		and used it until about a		must be developed with		
	week ago.			completion of the comp assessment. The care		
	The Assistant Physic	al Therapist was interviewed		reviewed and revised b	-	
		M. She stated the resident		interdisciplinary team a	-	
		hen she first came in. She		assessment, including		
		ent was independent getting		comprehensive and qu		
		ssing, bathing and walking in		assessments. The care	e plan must	
		. When the resident first		address accurate need		
		used a gait belt. She also		activities of daily living	-	
	I stated the Minimum I	Data Set nurse would update		locomotion and transfe	r abilities This	

Facility ID: 923121

If continuation sheet Page 6 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	345390		B. WING		C 04/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/23/2010
COUNTRY	SIDE MANOR			7700 US 158 EAST STOKESDALE, NC 27357	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIO
F 657	Continued From page	e 6	F 657	,	
	care plan to be review	y when it was time for the wed. She added that the changed on the care plan if		education will also be included in the orientation of any new MDS Nurses.	
	1:27 PM. She stated last updated on 4/15/ needed 1-2 person at that the resident did r anymore. She stated independent with am therapy goals. She st this (short term reside initial care plan. Ther plan meeting a few w updated the care plan (physical therapy). Sh assistants have acce the computer so they care for the residents The Director of Nursi PM that the care plan 30 days and the care admission assessme	the resident was bulation and had met her rated that for residents like ents), they would have an a they would have a care reeks later and would in after talking to therapy ne stated that the nursing ss to the entire care plan on know how to transfer and d. in g stated on 4/25/18 at 2:03 in was usually updated every plan was based on her int. If a resident had a in they would update the care		The monitoring procedure to ensure to the plan of correction is effective and specific deficiency cited remains corre- and/or in compliance with the regulate requirements; The Director of Nursing and/or Administrator will conduct a review us the Care Plan Audit Tool: Activities of Living to ensure the care plans are up date and addressing any changes in to resident's locomotion and transfer abilities. The review will include auditi resident care plans a week for 4 week and then 5 resident care plans a mone for 2 months. Identified issues will be addressed with appropriate action. Reports will be presented to the QA committee by the Administrator and/od Director of Nursing to ensure corrective action for trends or ongoing concerns initiated as appropriate. The QA Meet is attended by the Director of Nursing MDS Coordinator, Unit Manager, The Health Information Manager (HIM), and the Administrator.	that ected ory sing Daily to to the ing 5 ks th or ve is eting , erapy,
	Food Procurement,S		F 812	The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing and/or Administra Date of Compliance: May 22nd, 2018	tor

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/25/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345390	B. WING		C 04/25/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
COUNTRYSIDE MANOR				7700 US 158 EAST	
	1			STOKESDALE, NC 27357	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 812	Continued From page	e 7	F 812		
	The facility must -				
	state or local authorit (i) This may include fi from local producers, and local laws or regu (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision doo from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by:	red satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional		F812- Food Procurement,	
	by date and failed to	rd a food item within the use ensure foods were labeled, ealed containers. This was en observations.		Store/Prepare/Serve-Sanitary The statements made on this Plan of Correction are not an admission to a not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and Sta	and do e
	An observation of the	kitchen on 4/23/18 at 10:30 /anager (DM) revealed the		Regulations the facility has taken or take the actions set forth in this Plar Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged	r will n of
	of macaroni salad wit b. The walk-in refrige thawed mighty shake a use by date. c. The walk-in freeze	rator had an open container th a label dated 4/13/18. rator contained a case of s that were not labeled with r had a case of chicken kiev, and a case of beef steak		deficiencies cited have been or will corrected by the date or dates indica The plan of correcting the specific deficiency. The plan should address processes that lead to the deficiency cited; The facility failed to discard a food it	ated. s the y

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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	A. BUILDING		
	345390	B. WING		C 04/25/2018	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/20/2010	
COUNTRYSIDE MANOR					
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	
burgers that were ope the air. d. The reach-in refrig individual size pizzas and exposed to the a An interview with the revealed the macaron discarded within 7 da mighty shakes should thawed and used with DM added all food pr properly after being of An interview with the 2:06 pm revealed it w	en, unsealed and exposed to gerator had a plastic bag of a that was open, unsealed air. DM on 4/23/18 at 10:50 am ni salad should have been ays of opening. He stated the d be dated when they are hin 10 days of thawing. The roducts should be sealed opened. Administrator on 4/25/18 at vas his expectation that all	F 812	 within the use by date and failed to foods were labeled, dated, and stor sealed containers. A. The open container in the walk refrigerator with a label dated 4/13/ discarded on 4/23/18 by the Dietary Manager. B. The case of thawed mighty shat the walk-in refrigerator that were nor labeled were opened and dated on 4/23/18 by the Dietary Manager. C. The case of chicken kiev, case French fries, and the case of beef se burgers that were open, unsealed at exposed to air were discarded on 4/23/18 by the Dietary Manager. D. The plastic bag of individual siz pizzas that were open, unsealed ar exposed to air in the reach-in refrigivere discarded on 4/23/18 by the Dietary Manager. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The Administrator and Dietary Manage audited the entire kitchen and food storage location to ensure all food i were stored in the appropriate sealed containers, labeled and dated. This was completed on 4/27/18. The Dietary Manager and Administr re-educated all Dietary staff on the requirements for labeling, dating, an storing food in appropriate sealed 	ed in -in 18 was / akes in of teak and /23/18 ze id erator Dietary e ager tems ed audit rator nd	
	Continued From pag burgers that were op the air. d. The reach-in refrig individual size pizzas and exposed to the a An interview with the revealed the macaro discarded within 7 da mighty shakes should thawed and used wit DM added all food pr properly after being of An interview with the 2:06 pm revealed it v foods were stored, la	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345390 ROVIDER OR SUPPLIER SIDE MANOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 burgers that were open, unsealed and exposed to the air. d. The reach-in refrigerator had a plastic bag of individual size pizzas that was open, unsealed and exposed to the air. An interview with the DM on 4/23/18 at 10:50 am revealed the macaroni salad should have been discarded within 7 days of opening. He stated the mighty shakes should be dated when they are thawed and used within 10 days of thawing. The DM added all food products should be sealed properly after being opened. An interview with the Administrator on 4/25/18 at 2:06 pm revealed it was his expectation that all foods were stored, labeled and dated according	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345390 B. WING	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345390 B. WING COMDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIDE MANOR STREET ADDRESS, CITY, STATE, ZIP CODE IDENTIFICATION NUMBER: STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 8 ID burgers that were open, unsealed and exposed to the air. F 812 An interview with the DM on 4/23/18 at 10:50 am revealed the macaroni salad should have been discarded within 7 days of opening. He stated the mighty shakes should be dated when they are thawed and used within 10 days of thawing. The DM added all food products should be sealed properly after being opened. The case of thawed mighty sha the walk.in refrigerator that were one labeled were opened and dated and 42/2/18 by the Dietary Manager. C. The case of chicken kiev, case French fries, and the case of bears of burgers that were open, unsealed a exposed to air in the reach-in refrig were discarded on 4/23/18 by the Dietary Manager. D. The plastic bag of individual sic pizzas that were open, unsealed a exposed to air in the reach-in refrig were discarded on 4/23/18 by the Dietary Manager. D. The plastic bag of individual sic pizzas that were open, unsealed a exposed to air in the reach-in refrig were discarded on 4/23/18 by the D Manager. The procedure for implementing the acceptable plan of correction for thu specific deficiency c	

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE (CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		COMPLETED		
	345390		B. WING _	B. WING			C / 25/2018
NAME OF PF	NAME OF PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	COUNTRYSIDE MANOR				00 US 158 EAST		
				ST	TOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From pag	je 9	F	312			
					new Dietary employees.		
					The monitoring procedure to ensure the plan of correction is effective and specific deficiency cited remains corrand/or in compliance with the regulat requirements;	that ected ory	
					The Administrator will conduct a kitch tour with the Dietary Manager using t Food Storage Audit Tool. The audit w include weekly kitchen tours to includ food storage locations for 4 weeks ar	he rill le all	
					monthly for 2 months. Identified issue be addressed with appropriate action Reports will be presented to the QA committee by the Administrator to en- corrective action for trends or ongoing	sure g	
					concerns is initiated as appropriate. QA Meeting is attended by the Direct Nursing, MDS Coordinator, Unit Man Therapy, Health Information Manage (HIM), Dietary Manager, and the	or of ager,	
					Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator Date of Compliance: May 22nd, 2018		

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