	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		с	
		345390	B. WING		10/26/2020	
NAME OF PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	SIDE		-	7700 US 158 EAST		
COUNTRY	OIDE		:	STOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 000	INITIAL COMMENTS	3	F 000			
	conducted 10/21/20 2RHD11 5 of 5 of the complain	mplaint investigation was through 10/26/20. Event ID nt allegations were icient practice was identfied				
F 607 SS=D	Develop/Implement A CFR(s): 483.12(b)(1)	Abuse/Neglect Policies -(3)	F 607	7	11/9/20	
	§483.12(b) The facili implement written po	ty must develop and licies and procedures that:				
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of r					
	§483.12(b)(2) Establ to investigate any su	ish policies and procedures ch allegations, and				
	paragraph §483.95,	e training as required at Γ is not met as evidenced				
	Based on record rev interview the facility f reporting requirement	iew, policy review and staff ailed to include the 2-hour t for abuse allegations to the		F607- Develop/Implement Abuse/Ne Policies		
		abuse policy. This was idents reviewed for abuse sident #2).		The statements made on this Plan of Correction are not an admission to ar not constitute an agreement with the alleged deficiencies. To remain		
	Findings Included:			incompliance with all Federal and Sta Regulations the facility has taken or v	vill	
	Neglect, Mistreatmer Property and Crime a revision date of 8/23/	es policy titled "Abuse, nt and Misappropriation of against a Resident" with a '19 stated in part: "The		take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged		
	Administrator or Des	ignee should send a 24-hour		deficiencies cited have been or will be	e	

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.

11/09/2020

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345390 B. WING 10/26/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US 158 EAST COUNTRYSIDE STOKESDALE, NC 27357 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 607 Continued From page 1 F 607 report to state agency / healthcare personnel corrected by the date or dates indicated. registry postmarked or faxed within 24 hours of The plan of correcting the specific the alleged incident or 24 hours of notification of deficiency. The plan should address the the incident. If the resident sustained an injury, processes that lead to the deficiency report to the healthcare personnel registry and cited. law enforcement within 2 hours of becoming aware of the event." Address how corrective action will be accomplished for those residents found to 1. Resident #1 was admitted to the facility on have been affected by the deficient 7/21/20 and diagnoses included cerebral practice; Address how the facility will infarction, osteoarthritis and atrial fibrillation. identify other residents having the potential to be affected by the same Review of the facilities abuse investigation deficient practice. revealed Resident #1 had reported to the Physical Therapy Assistant (PTA) and to Nurse The facility failed to include the 2-hour #1 that Nursing Assistant #1 had hit her on her reporting requirement for abuse left cheek. The initial allegation report was allegations to the state agency in their completed by Administrator #1 and identified the abuse policy. This was evident for 2 of 2 allegation as resident abuse. The report identified residents reviewed for abuse. the incident occurred on 9/3/20 at 6:45 am. The After a thorough review, no residents were report did not identify when the facility became found at the time to be affected by the aware of the incident. A fax transmission deficient practice in which the facility failed verification report identified the initial abuse to include the 2-hour reporting allegation report was sent to the state agency on requirement for any abuse allegations in 9/3/20 at 10:46 am. our abuse policy. Immediate actions were taken on each abuse allegation to ensure During an interview on 10/21/20 at 2:35 am with safety of the residents involved and all the DON and Administrator #1 they both stated it other residents. was their understanding they had 24 hours to To identify residents having the potential submit an initial allegation report of resident abuse to the state agency unless the abuse to be affected by the same deficient involved an injury; then they needed to submit the practice, a new abuse policy and initial allegation report within 2 hours of becoming procedure was implemented with the QA aware of the incident. Administrator #1 stated she committee on October 22nd, 2020. would need to follow-up to make sure their abuse Training was held on 10/22 with all staff policy was correct regarding reporting on new abuse policy. Ongoing training will requirements to the state agency. be held with all staff including the facility contracted therapy department regarding 2. Resident #2 was admitted to the facility on the new abuse and neglect policy and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923121

If continuation sheet Page 2 of 9

TATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	C			
		345390	B. WING		10/26/2020		
NAME OF P	ROVIDER OR SUPPLIER	I	STREET ADDRESS, CITY, STATE, ZIP CODE		•		
COUNTRYSIDE			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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE COMPLÉTIO		
F 607	Continued From page	e 2	F 607	7			
	6/17/18 and diagnoses included chronic obstructive pulmonary disease, congestive heart failure, diabetes and dementia.			procedures. Abuse allegation from November 2019 to current were re by Administrator in which showed r residents affected.			
	member of Resident a (NA) was verbally and Resident #2. The initi completed by Adminis allegation as resident the facility became av on 11/11/19 at 10:30 verification report idea allegation report was agency on 11/12/20 a An interview on 10/20 Administrator #2 reve Administrator #2 reve Administrator at the fa the abuse investigation stated an initial abuse be submitted to the st of the facility becomina abuse. He added if the an injury then the initial be submitted within 2 stated he was not aw report all abuse allega state agency and he	vas notified by a family #2 that a Nursing Assistant d emotionally abusive to al allegation report was strator #2 and identified the abuse. The report identified ware of the abuse allegation am. A fax transmission ntified the initial abuse submitted to the state at 12:22 pm.		Address what measures will be put place or systemic changes made to ensure what the deficient practice; On 10/22, the Administrator, Direct Nursing and QA Committee implem a new policy and procedure for Abu Neglect. The new policy and proce Abuse and Neglect includes but no limited to the state agency being new within two (2) hours if the alleged v involves abuse or has resulted in s bodily injury. See attachment for Abuse and Neglect policy and procedure. Abuse and Neglect audit form was reviewed by Administrator and was implemented on 10/28. Training was held on 10/22 with all which included but not limited to Administrator, Director of Nursing, Assistant, Plant Operations, Housekeeping Manager, Director of Human Resource, MDS Coordinator Nursing Supervisors, Director of Th Admissions Coordinator, direct car etc. Ongoing in-services will be con on the new Abuse and Neglect policy all staff. The in-services will review new Abuse and Neglect policy and two-hour requirement for any alleg violation involving abuse or has res	o of nented use and dure for of ot otfied iolation erious buse The staff Dietary of or, nerapy, e staff nducted icy for the the the ed		

Event ID: 2RHD11

Facility ID: 923121

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/30/2020 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345390	B. WING _				C 26/2020
NAME OF PROVIDER OR SUPPLIER				ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1	
	(0)DE			77	700 US 158 EAST		
COUNTRY	SIDE			ST	TOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 607	Continued From page	e 3	F	607	DEFICIENCY) copy of the revised abuse and neglect policy. Countryside will continue to require all new hires to view the abuse and neglect video on Care Learning before starting their first shift. The new abuse and neglect policy will be added to the in-person employee orientation. All ne hires will be educated on our new Abu and Neglect policy as well as and the (2) hour notification requirement to the state agency for alleged violations in which involves abuse or has resulted serious bodily injury. See attachment the Abuse and Neglect Policy and Procedure. Indicate how the facility plans to monifi its performance to make sure that solutions are sustained; and Include do when corrective action will be complet The Administrator/ Designee will audit abuse and neglect cases to monitor the Countryside is following the revised at and neglect policy and procedure. The Administrator/ Designee will revise the Abuse and Neglect audit form oncome week for the first 4 weeks to ensure Countryside's Abuse and Neglect Polic being followed properly per revised polic Thereafter, Administrator/ Designee will revise the Abuse and Neglect audit form oncome week for the first 4 weeks to ensure Countryside's Abuse and Neglect Polic being followed properly per revised polic thereafter, Administrator/ Designee will review the Abuse and Neglect audit for once a month for the next three month for any abuse allegation to ensure all	ect g w ise two for for ates ed. all at buse w e a cy is blicy. rill rm	
					allegations are being followed correctl per revised policy. The Abuse and Ne		

Event ID: 2RHD11

Facility ID: 923121

If continuation sheet Page 4 of 9

		ID HUMAN SERVICES MEDICAID SERVICES				RM APPROVE 10. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345390	B. WING		1	C 0/26/2020	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
COUNTRY	(SIDE			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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 607	Continued From page		F 607	audits/reports will be reviewed at t monthly QA committee meeting by Administrator/Designee to ensure corrective action for trends or ong concerns is initiated as appropriat The QA Meeting is attended by the Medical Director, Director of Nursi MDS Coordinator, Nursing Superv Therapy, Administrator and other departmental managers.	y the oing e. e ng,	11/9/20	
SS=D	CFR(s): 483.12(c)(1)(§483.12(c) In respons neglect, exploitation, must: §483.12(c)(1) Ensure	(4) se to allegations of abuse, or mistreatment, the facility e that all alleged violations					
	source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of th officials (including to adult protective servic for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the a	ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345390 B. WING 10/26/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US 158 EAST COUNTRYSIDE STOKESDALE, NC 27357 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 609 Continued From page 5 F 609 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interview the F609- Reporting of Alleged Violations facility failed to submit an initial resident abuse allegation to the state agency with the required Address how corrective action will be 2-hour timeframe for 2 of 2 residents reviewed for accomplished for those residents found to abuse. (Resident #1 and Resident #2). have been affected by the deficient practice; Address how the facility will Findings Included: identify other residents having the potential to be affected by the same 1. Resident #1 was admitted to the facility on deficient practice. 7/21/20 and diagnoses included cerebral infarction, osteoarthritis and atrial fibrillation. The facility failed to submit an initial resident abuse allegation to the state An admission minimum data set (MDS) dated agency within the required 2-hour 7/28/20 for Resident #1 identified her cognition timeframe for 2 of 2 residents reviewed was moderately impaired and she required for abuse. extensive one-person assistance with personal Immediate actions were taken on each hygiene, toilet use and bed mobility. No behaviors abuse allegation to ensure safety of the were identified during the look-back period. residents involved and all other residents. Review of the facilities abuse investigation After a thorough review of all resident revealed Resident #1 had reported to the abuse allegations from November 2019, Physical Therapy Assistant (PTA) and to Nurse none were found at the #1 that Nursing Assistant #1 had hit her on her time to be affected by the deficient left cheek. The initial allegation report was practice. completed by Administrator #1 and identified the allegation as resident abuse. The report identified To identify residents having the potential the incident occurred on 9/3/20 at 6:45 am. The to be affected by the same deficient report did not identify when the facility became practice, a new Abuse and Neglect policy aware of the incident. A fax transmission and procedure was implemented with the verification report identified the initial abuse QA committee on October 22nd, 2020. allegation report was sent to the state agency on Training was held on 10/22 with all staff. 9/3/20 at 10:46 am. Ongoing training will be held with all staff including the contracted therapy

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Event ID: 2RHD11

Facility ID: 923121

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	OF DEFICIENCIES	MEDICAID SERVICES	(Y2) MI II TI		CONSTRUCTION		IO. 0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	IPLETED
			A. BOILDIN	···			С
		345390	B. WING			1	0/26/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2020
COUNTRYSIDE				77	700 US 158 EAST		
				S	TOKESDALE, NC 27357		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETIC
F 609	Continued From page	e 6	F 6	09			
		es 5-day report summary			department regarding the new abuse	and	
		he Director of Nursing (DON)			neglect policy and procedures and the		
		about 9:00 am on 9/3/20 and			(2) hour notification requirement to the		
	was immediately noti			state agency for alleged violations in			
	#2 of the alleged abu			which involves abuse or has resulted			
	#1.				serious bodily injury. See attachment	for	
					the Abuse and Neglect Policy and		
	An interview on 10/22			Procedure.			
		PTA revealed she had received an allegation of staff to resident abuse from Resident #1. She					
		stated she had received training on abuse, and it			Address what measures will be put int	0	
	was her understandir			place or systemic changes made to ensure what the deficient practice;			
		he resident 's nurse and the			ensure what the dencient practice,		
		up the chain of command.			On 10/22, the Administrator, Director	of	
					Nursing and the QA committee		
	An interview on 10/22	2/20 at 1:00 pm with Nurse			implemented a new policy and proced	lure	
		ecall the abuse allegation			for Abuse and Neglect. The new polic		
	from Resident #1 and			and procedure for Abuse and Neglect	-		
	aware of the incident at 6:45 am on 9/3/20. She				includes but not limited to the state		
	explained she had no	otified Nurse #2 around 7:15			agency being notified within two (2) he	ours	
		se Manager on duty. Nurse			if the alleged violation involves abuse		
		ot sure if Nurse #2 contacted			has resulted in serious bodily injury. S		
	the DON or Administr	rator about the abuse			attachment for Abuse and Neglect pol		
	allegation.				and procedure. The Abuse and Negle		
	An interview on 10/00	2/20 at 3:00 pm with Nurse			audit form was reviewed by Administra	alor	
		ked as both a floor nurse and			and was implemented on 10/28.		
		stated when she arrived to			Training was held on 10/22 with all sta	aff	
	work on 9/3/20 Nurse				which included but not limited to	a11	
		ation of abuse. Nurse #2			Administrator, Director of Nursing, Die	etary	
		recall if she called the			Assistant, Plant Operations,		
	Administrator to notify	y her of the abuse allegation			Housekeeping Manager, Director of		
		the DON when she arrived			Human Resource, MDS Coordinator,		
		am. Nurse #2 added she had			Nursing Supervisors, Director of Thera		
	been trained on abus				Admissions Coordinator, direct care s		
		pposed to be contacted as			etc. Ongoing in-services will be condu		
	soon as an abuse all	egation occurred.			on the new Abuse and Neglect policy		
					all staff. The in-services will review the		
	An interview on 10/2	1/20 at 2:30 pm with the			new Abuse and Neglect policy and the	3	

Facility ID: 923121

		MEDICAID SERVICES				NO. 0938-03	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				
						с	
		345390	B. WING			10/26/2020	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
COUNTRYSIDE			7700 US 158 EAST STOKESDALE, NC 27357				
()(4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLETIO	
F 609	Continued From page	e 7	F 60	9			
		as notified of the alleged		two-hour requirement for any	alleged		
		Resident #1 at approximately		violation involving abuse or h			
	-	nen she arrived at the facility.		serious bodily injury. All staff			
		should have contacted her		copy of the revised abuse an	d neglect		
		when she became aware of		policy.			
	the incident at 6:45 a	m.		Countryside will continue to r	مصينته وال		
	During an interview o	n 10/21/20 at 2:35 am with		Countryside will continue to r new hires to view the abuse			
		strator #1 they both stated it		video on Care Learning befor	0		
		ing they had 24 hours to		their first shift. The new abus	-		
		ation report of resident		neglect policy will be added t	o the		
	abuse to the state ag	ency unless the abuse		in-person employee orientation	on. All new		
		en they needed to submit the		hires will be educated on our			
		t within 2 hours of becoming		and Neglect policy as well as	the 2-hour		
		Administrator #1 confirmed		requirement.			
		eport they were using did not cument when the facility		Training will be held 11/11 for	all nurses in		
		abuse allegation. She		order to review the Initial Rep			
		ed to follow-up to make sure		document that is to be turned			
		s correct regarding reporting		2-hours of being notified of a			
		t they were using the most		allegation. Blank Initial Invest	•		
	recent 24-hour report			will be kept at nurses' station	. Charge		
				Nurses and Nursing supervis			
		dmitted to the facility on		in-serviced on completing the			
	6/17/18 and diagnose			investigation report at the dire			
	failure, diabetes and	y disease, congestive heart dementia		Administrator/Director of Nur	sing.		
		demontia.		Indicate how the facility plans	s to monitor		
	A quarterly minimum	data set (MDS) dated		its performance to make sure			
		t #2 identified her cognition		solutions are sustained; and			
	was intact; she requir	ed extensive one-person		when corrective action will be	e completed.		
		use, dressing and bed					
		no behaviors identified		The Administrator/ Designee			
	during the look-back	period.		abuse and neglect cases to r			
	Dovious of the feetilitie	a abuaa invastigation		correctly following the update			
		s abuse investigation /as notified by a family		neglect policy and procedure 2-hour reporting requirement			
	-	#2 that a Nursing Assistant					
	(NA) was verbally and			Administrator/ Designee will			

Facility ID: 923121

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING	с			
		345390	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	10/26/2020	
NAME OF PROVIDER OR SUPPLIER			S			
			7			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		NCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO			
F 609	completed by Administration as resident the facility became as on 11/11/19 at 10:30 verification report ide allegation report was	al allegation report was strator #2 and identified the t abuse. The report identified ware of the abuse allegation am. A fax transmission ntified the initial abuse submitted to the state	F 609	Abuse and Neglect audit log once a for the first 4 weeks and then once month for the next three months to allegations were reported within the appropriate time frame per revised The Abuse and Neglect audits/repo be reviewed at the monthly QA con	a ensure policy. prts will nmittee	
	Social Worker (SW) r abuse allegation subr Resident #2. She exp had written a stateme and emotionally abus plan invitation and ma stated when she rece and saw the written a	2/20 at 11:20 am with the revealed she did recall the mitted by the family of blained the family member ent that NA #2 was verbally sive to the resident on a care ailed it to the facility. The SW sived the care plan invitation		meeting by the Administrator/Desig ensure corrective action for trends ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Medical Director, Director of Nursin MDS Coordinator, Nursing Supervi Therapy, Administrator and other departmental managers.	or Ig,	
	Administrator at the fa the abuse investigation stated an initial abuse be submitted to the si of the facility becominabuse. He added if the an injury then the initiable submitted within 2 explained the facility abuse from the family initiated an abuse invo could not recall the explained the site	6/20 at 11:00 am with ealed he had been the acility and had completed on for Resident #2. He e investigation report had to tate agency within 24 hours ing aware of the alleged he abuse allegation included ial investigation report had to the hours. Administrator #2 had received an allegation of y of Resident #2 and he had restigation. He added he xact date or time the initial eport was sent to the state				

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