PRINTED: 02/01/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245200	P WING				С
		345390	B. WING			12/	15/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	SIDE			7700 US 158 EAST			
000	0.52			S	TOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	complaint investigation 12/12/22 through 12/ in compliance with the	15/22. The facility was found e requirement CFR 483.72, Iness. Event ID # 1MKY11.	F	000			
	A recertification survey and complaint investigation survey were conducted from 12/12/22 through 12/15/22. Event ID# 1MKY11. The following intake was investigated NC00191849.						
F 638 SS=E	· ·	allegations were not Least Every 3 Months	F	638			1/20/23
	and approved by CM once every 3 months	s a resident using the ument specified by the State S not less frequently than					
	Based on record rev facility failed to comp Set (MDS) assessment after the Assessment	iew and staff interviews, the lete quarterly Minimum Data ents no later than 14 days Reference Date (ARD, the			F638- Qrtly Assessment at Least Ever Months 483.20- Quarterly Review Assessment	•	
		ack period) for 4 residents					
	,	4, and #16) reviewed for			The plan of correction is prepared and		
	resident assessments	S.			submitted solely because of requireme		
	The findings included				of state and federal law. The statement made on this Plan of Correction are no an admission to and do not constitute a	t an	
		dmitted to the facility on			agreement with the alleged deficiencies		
	4/7/21.				To remain incompliance with all Federa	ıl	
A B O D A T O D V	NIDECTOR'S OR PROVINER/	SUPPLIER REPRESENTATIVE'S SIGNATUE	)E		TITI F		(X6) DATE

01/06/2023 **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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345390	B. WING			C
NAME OF D	ROVIDER OR SUPPLIER	0.0000	<del>-</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	ı	12/15/2022
NAME OF T	NOVIDER OR SOLT EIER					
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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 638	Continued From page	e 1	F 63	88		
	Review of the resider (MDS) assessment re an Assessment Refer day of the look-back 12/15/22, 24 days aft MDS dated had not be An interview was con PM with the facility's indicated she was be assessments, which be overdue. She indiget them completed, pulled from the MDS medication cart and if the assessments. She	nt's Minimum Data Set evealed a quarterly MDS had rence Date (ARD, the last period) of 11/21/22. As of er the ARD, the quarterly		and State Regulations the facilitaken or will take the actions set this Plan of Correction. The Plat Correction constitutes the facilital allegation of compliance such the alleged deficiencies cited have will be corrected by the date or indicated. The plan of correctin specific deficiency. The plan shaddress the processes that lead deficiency cited.  Address how corrective actions accomplished for those resident have been affected by the deficientify other residents having the potential to be affected by the sedeficient practice.	et forth in an of ty's hat all been or dates g the hould d to the will be hits found to cient ity will the	
	PM with the facility's interview, the Administrative aware of concerns reassessments being on She indicated resider had to assign the MD medication cart at time coordinator was work completed and caugh indicated it was here assessments are concerns. Resident #7 was a 6/15/22.	verdue and not completed. In the care was their priority and less. She indicated the MDS less the assessments less. The Administrator expectation that the MDS		The facility failed to complete q Minimum Data Set (MDS) asset no later than 14 days after the Assessment Reference Date (A last day of the look-back period residents (Residents #8, #7, #1 #16) reviewed for resident asset After a review of the deficient p of 8 residents (Resident #8, #7 were found to have been affect however, no residents were at deficient practice. To identify ar residents having the potential to affected by the same deficient paudit was performed on 1/20/20 audit reviewed residents from N	ARD, the did, and essments.  Fractice, 5 (7, #14, #16) (1, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4,	
		evealed a quarterly MDS had rence Date (ARD, the last		1st,2022 to December 31st, 20 11 out of 23 residents were fou		

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l' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CATION NI IMBED:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
						С		
		345390	B. WING _			12/	/15/2022	
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
				77	700 US 158 EAST			
COUNTRY	SIDE			S	TOKESDALE, NC 27357			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			(X5)	
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 638	Continued From pa	F 6	638					
	day of the look-bac	k period) of 11/21/22. As of			affected by the same deficient practice	<b>.</b>		
	12/15/22, 24 days a	after the ARD, the quarterly			However no residents were at harm of	the		
	MDS dated had no			deficient practice. As of 1/20/2023 all				
				quarterly MDS assessments found to l	эе			
		onducted on 12/15/22 at 12:25			affected from deficient practice from			
		s MDS Coordinator and she			November 1st, 2022 through December			
	indicated she was l			31st, 2022 audit are completed and up	to to			
	assessments, whic			date. As of 1/2/2023, facility has	_			
		ndicated she was working to d. She indicated she had been			implemented an audit tool to ensure nother residents are affected by the	3		
				deficient practice going forward.				
		S department to work on the had fell behind in completing			delicient practice going forward.			
		She indicated the assessments			After review of the deficient practice,			
		ed in 14 days from the ARD.			education was conducted by			
	'	,			Administrator/Designee on 1/2/2023 w	ith		
	An interview was co	onducted on 12/15/22 at 4:30			the Administrator, Director of Nursing,	and		
	PM with the facility'	s Administrator. During the			MDS Coordinator to review MDS			
		nistrator indicated she was			assessments to be completed no later			
	aware of concerns				than 14 days after the ARD.			
	_	overdue and not completed.						
		ent care was their priority and						
		IDS coordinator to the			A -1-1	_		
		imes. She indicated the MDS			Address what measures will be put int	5		
		orking to get the assessments ght up. The Administrator			place or systemic changes made to ensure what the deficient practice;			
		expectation that the MDS			crisure what the deficient practice,			
	assessments are o	-			On 1/2/2023, education was conducte	d bv		
		p			Administrator/Designee with the	<i>y</i>		
	3. Resident # 14 wa	as admitted to the facility on			Administrator, Director of Nursing and			
	3/25/15.	ŗ			MDS Coordinator to review MDS			
					assessments to be completed no later			
	Review of the resid	ent's Minimum Data Set			than 14 days after the ARD. Administr			
	` '	revealed a quarterly MDS had			Director of Nursing and MDS Coordina			
		ference Date (ARD, the last			will meet weekly to review assessmen			
	·	k period) of 11/22/22. The			and ARD to ensure completion no late			
		ed 11/22/22 was signed/dated			than 14 days after the ARD. An audit v			
		Assessment Coordinator to			be conducted utilizing a calendar tool			
		ent was completed (22 days			ensure completion of MDS assessmen			
	after the ARD).		1		that are due no later than 14 days afte	1		

Facility ID: 923121

Event ID: 1MKY11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		345390	B. WING			С	
	201/1252 02 01/221/52	343390	B. WING		TREET ARRESTO CITY OTATE TIR CORE	12/	15/2022
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	SIDE				700 US 158 EAST		
				S	TOKESDALE, NC 27357		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	BALL
					,		
F 638	Continued From page	e 3	F	638			
					ARD.		
	An interview was con						
	PM with the facility's I	MDS Coordinator and she			On 1/3/2023, Administrator reviewed w	ith	
	indicated she was be	hind in completing some			QA team of weekly meetings to ensure		
	assessments, which	caused the assessment to			completion of MDS assessments are		
	be overdue. She indi	cated she was working to			completed no later than 14 days after t	he	
	get them completed.	She indicated she had been			ARD. The QA committee consists of		
		department to work on the			Medical Director (only quarterly), DON,		
		nad fell behind in completing			Administrator, MDS Coordinator, Nursi	ng	
		e indicated the assessments			Supervisor, Human Resource, Social		
	should be completed	in 14 days from the ARD.			Worker, Plant Operations Manager,		
					Pharmacy Consultant (only quarterly) a	and	
		ducted on 12/15/22 at 4:30			other departmental managers.		
		Administrator. During the					
		strator indicated she was			Weekly meetings between the		
	aware of concerns re				Administrator, Director of Nursing and		
		verdue and not completed.			MDS Coordinator will be held for the ne		
		nt care was their priority and			4 weeks and thereafter once a month f	or	
	had to assign the MD				the next 3 months.		
		es. She indicated the MDS					
		ing to get the assessments					
		nt up. The Administrator					
		xpectation that the MDS			Indicate how the facility plans to monito	)r	
	assessments are con	ipieted timety.			its performance to make sure that solutions are sustained; and Include da	atoc	
	1 Posidont #16 was	admitted to the facility on					
	4. Resident #10 was 1	admitted to the facility on			when corrective action will be complete	;u.	
	4/21/21.				On 1/3/2023, Administrator reviewed v	with	
	Paview of the resider	nt's Minimum Data Set			QA team of weekly meetings to ensure		
		evealed a quarterly MDS had			completion of MDS assessments are		
	, ,				completed no later than 14 days after t	he	
	an Assessment Reference Date (ARD, the last day of the look-back period) of 11/5/22. The				ARD. The QA committee consists of		
		11/5/22 was signed/dated			Medical Director (only quarterly), DON,		
		ssessment Coordinator to			Administrator, MDS Coordinator, Nursi		
		t was completed (16 days			Supervisor, Human Resource, Social	9	
	after the ARD).				Worker, Plant Operations Manager,	ĺ	
					Pharmacy Consultant ( only quarterly)	and	
	An interview was con	ducted on 12/15/22 at 12:25			other departmental manager.	ĺ	
		MDS Coordinator and she					

Facility ID: 923121

Event ID: 1MKY11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345390	B. WING _		_	C 12/15/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 7700 US 158 EAST STOKESDALE, NC 2735		12/13/23/2
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORREC CROSS-REFEREN D	DATE.	
F 640 SS=B	indicated she was bei assessments, which obe overdue. She indiget them completed. I pulled from the MDS medication cart and he the assessments. She should be completed. An interview was con PM with the facility's vinterview, the Administ aware of concerns reassessments being of She indicated resider had to assign the MD medication cart at time coordinator was work completed and caugh indicated it was here assessments are comencoding/Transmitting CFR(s): 483.20(f)(1)- §483.20(f) Automated requirement- §483.20(f) Automated requirement- §483.20(f) I Encodir a facility must encode the each resident in the facility must encode the each resident in the facility formula assessments in the facility of the property of	caused the assessment to cated she was working to She indicated she had been department to work on the lad fell behind in completing endicated the assessments in 14 days from the ARD.  Inducted on 12/15/22 at 4:30 Administrator. During the strator indicated she was garding the MDS werdue and not completed. In care was their priority and S coordinator to the less. She indicated the MDS ing to get the assessments of the up. The Administrator expectation that the MDS ingleted timely. In g Resident Assessments (4)  If data processing and data. Within 7 days after resident's assessment, a le following information for accility: ment. In the updates. In the instatus assessments. In the procession are sident's transfer, and death. In the east of the resident's transfer, and death. In the procession information, if there	F	Weekly meetings be Administrator, Direct MDS Coordinator was 4 weeks and thereathe next 3 months.  Reports/Audits will be committee monthly or Director of Nursing corrective action for concerns is initiated QA committee constructions. Director (only quarted Administrator, MDS Supervisor, Human Worker, Plant Open Pharmacy Consultated other departmental	ctor of Nursing and will be held for the neafter once a month for the presented to the by MDS Coordinate on trends or ongoing das appropriate. The sists of Medical cerly), DON, a Coordinator, Nursing Resource, Social rations Manager, ant (only quarterly) a	or e QA por ure ne

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	345390	B. WING		C 12/15/2022		
			STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US 158 EAST STOKESDALE, NC 27357	1111012022		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION		
Continued From page 5  §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.  §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:  (i) Admission assessment.  (ii) Significant change in status assessment.  (iv) Significant correction of prior full assessment.  (v) Significant correction of prior quarterly assessment.  (vi) Quarterly review.  (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.  (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.  §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by:		F 64		nt		
			483.20- Automated Data Processing			
	ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIEN REGULATORY OF  S483.20(f)(2) Transr after a facility compl a facility must be ca CMS System inform contained in the MD standard record layo and that passes star CMS and the State.  \$483.20(f)(3) Transr 14 days after a facilit assessment, a facilit encoded, accurate, the CMS System, in (i)Admission assess (ii) Annual assessme (iii) Significant correc (v) Significant correc (v) Significant correc (vi) Quarterly review (vii) A subset of item reentry, discharge, a (viii) Background (fa initial transmission of does not have an ac \$483.20(f)(4) Data for transmit data in the for a State which ha by CMS, in the form approved by CMS. This REQUIREMEN by: Based on record re facility failed to comp (MDS) discharge as	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.  §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:  (ii) Annual assessment.  (iii) Significant change in status assessment.  (iv) Significant correction of prior full assessment.  (vi) Guarterly review.  (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.  (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.  §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.  This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER  SIDE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  \$483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.  \$483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment.  (ii) Annual assessment.  (iii) Significant correction of prior full assessment.  (iv) Significant correction of prior full assessment.  (vi) Quarterly review.  (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.  (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.  \$483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.  This REQUIREMENT is not met as evidenced by:  Based on record review and staff interviews, the facility failed to complete Minimum Data Set (MDS) discharge assessments for 5 of 8	A BUILDING  345390  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US 158 EAST STOKESDALE, NC 27357  BUMMARY STATEMENT OF DETICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  \$483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.  \$483.20(f)(3) Transmittal requirements. 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This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Minimum Data Set (MDS) discharge assessments for 5 of 8		

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		345390	B. WING _				C / <b>15/2022</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12	11312022
	10115211 011 001 1 21211				700 US 158 EAST		
COUNTRY	SIDE				TOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 640	Continued From page	F 6	640				
	#62, #24, #47, #37).	s included:			Requirement		
	Findings included:  1. Resident #29 was				The plan of correction is prepared and submitted solely because of requirement of state and federal law. The statemen		
	6/17/22.			made on this Plan of Correction are no an admission to and do not constitute	t an		
	Nursing documentation dated 7/2/22 noted the resident had discharged from the facility to the community. There was no discharge MDS				agreement with the alleged deficiencie To remain incompliance with all Federa and State Regulations the facility has		
	completed for Reside	•			taken or will take the actions set forth i this Plan of Correction. The Plan of	n	
		ducted on 12/15/22 at 12:25			Correction constitutes the facility's		
		MDS Coordinator. She			allegation of compliance such that all		
		hind in completing some			alleged deficiencies cited have been o	r	
		ot completed the discharge			will be corrected by the date or dates		
		as working to get them			indicated. The plan of correcting the		
	from the MDS depart	ated she had been pulled			specific deficiency. The plan should address the processes that lead to the		
	· ·	nad fallen behind. She			deficiency cited.		
		ments should be completed			deliciency cited.		
	within 14 days from t	•			Address how corrective action will be		
	within 14 days noin t	ne disoriarge date.			accomplished for those residents found	d to	
	An interview was con	ducted on 12/15/22 at 4:30			have been affected by the deficient	110	
		Administrator. During the			practice; Address how the facility will		
	· ·	strator indicated she was			identify other residents having the		
	aware of concerns re				potential to be affected by the same		
		overdue and not completed.			deficient practice.		
		nt care was their priority and					
	had to assign the MD				The facility failed to complete Minimum	1	
	_	nes. She indicated the MDS			Data Set (MDS) discharge assessmen		
	coordinator was working to get the assessments				for 5 of 8 discharged residents reviewe		
		nt up. The Administrator			(Residents #29, #62, #24, #47, #37).		
		expectation that the MDS			,		
	assessments are cor				After a review of the deficient practice,	5	
		- -			of 8 residents (Resident #29, #62, #24		
	2. Resident #62 was	admitted to the facility on			#47, #37) were found to have been		
	6/23/22.	-			affected, however no residents were a	t	
					harm of deficient practice. To identify a	ny	

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						(	c	
		345390	B. WING _			12/	15/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US 158 EAST STOKESDALE, NC 27357				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 640	resident had discharge community. There was completed for Resided An interview was completed for Resided An interview was completed she was be assessments, had not assessments, and was completed. She indicated from the MDS depart medication cart and laindicated the assession within 14 days from the An interview was completed. An interview was completed to assessments being the same of concerns reassessments are same of concerns reassessments being the same of concerns reassessments are same of concerns reassessments are same of concerns reassessments are same of concerns reassessments being the same of concerns reassessments being the same of concerns reassessments are same of concerns reassessments being the same of concerns reassessments are same of concerns reassessments.	on dated 7/8/22 noted the ged from the facility to the as no discharge MDS ent #62.  Inducted on 12/15/22 at 12:25 MDS Coordinator. She whind in completing some of completed the discharge as working to get them atted she had been pulled ament to work on the mad fallen behind. She ments should be completed the discharge date.  Inducted on 12/15/22 at 4:30 Administrator. During the strator indicated she was agarding the MDS overdue and not completed. In the care was their priority and DS coordinator to the mes. She indicated the MDS atting to get the assessments and up. The Administrator expectation that the MDS	F6	340	other residents having the potential to affected by the same deficient practice audit was performed 1/20/2023. The aureviewed residents from December 1st through December 31st, 2022 in which showed 4 of 10 residents were affected the same deficient practice, however notes idents were at harm of the deficient practice. As of 1/20/2023 all discharge assessments from the December 1st, 2022 through December 31st, 2022 aure completed and up to date. As of 1/2/2023, facility implemented an audit tool to ensure no other residents are affected by the deficient practice going forward.  After review of the deficient practice, education was conducted by Administrator/Designee on 1/2/2023 with the Administrator, Director of Nursing, a MDS Coordinator to review MDS discharge assessments and the completion of discharge assessments later than 14 days from the discharge date.	, an udit d by o dit th and		
	7/6/22.  Nursing documentati resident had discharg assisted living facility MDS completed for FAn interview was completed.	nducted on 12/15/22 at 12:25			Address what measures will be put into place or systemic changes made to ensure what the deficient practice;  On 1/2/2023, education was conducted Administrator/Designee with the Administrator, Director of Nursing, and MDS Coordinator to review MDS discharge assessments to be complete	l by		
	PM with the facility's	MDS Coordinator. She	1		no later than 14 days after resident			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345390	B. WING _			12/	15/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	reine			77	700 US 158 EAST		
COUNTRI	SIDE			S	TOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 640	assessments, had no assessments, and wa completed. She indic from the MDS depart medication cart and hindicated the assessi within 14 days from to the MDS depart medication cart and hindicated the assessi within 14 days from to the MDS depart medicated the assessments being to the MDS depart medication cart at time coordinator was work completed and caugh indicated it was here assessments are conducted to the medication cart at time coordinator was work completed and caugh indicated it was here assessments are conducted. Resident #47 was 7/20/22.  Nursing documentation resident had discharge community. There was Resident #47.  An interview was completed she was be assessments, and was completed. She indicated she massessments, and was completed. She indicated the MDS depart medicated she was be assessments, and was completed. She indicated the MDS depart medicated she was be assessments, and was completed. She indicated she massessments, and was completed. She indicated she massessments, and was completed. She indicated she massessments are conducted to the medicated she was be assessments, and was completed. She indicated she massessments are conducted to the medicated she massessments are conducted to the medicated she was because of the medicated she was because o	whind in completing some of completed the discharge as working to get them ated she had been pulled ment to work on the mad fallen behind. She ments should be completed the discharge date.  Inducted on 12/15/22 at 4:30 Administrator. During the strator indicated she was agarding the MDS overdue and not completed. In the care was their priority and the observer of the mess. She indicated the MDS overdue and not completed to the mess. She indicated the MDS overdue and not completed the mess. She indicated the MDS overdue and the massessments of the mess	F	640	discharges. Administrator, Director of Nursing and MDS Coordinator will mee weekly to review discharge assessment and to ensure completion no later than days after the resident discharges. An audit will be conducted utilizing a calent tool to ensure completion of MDS discharge assessments that are due no later than 14 days after resident discharges.  On 1/3/2023, Administrator reviewed we QA team of weekly meetings to ensure completion of MDS discharge assessments are completed no later than 14 days after the discharge date. The Committee consists of Medical Director (only quarterly), DON, Administrator, M Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.  Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the new the Administrator of Nursing, and MDS Coordinator will be held for the new that weeks and thereafter once a month for the next 3 months.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include day when corrective action will be completed.  On 1/3/2023, Administrator reviewed when corrective action will be completed.	nts 14 14 ndar  rith an QA IDS an  ext or	
	Nursing documentation dated 8/3/22 noted the resident had discharged to from the facility to the community. There was no discharge MDS for				14 days after the discharge date. The committee consists of Medical Director (only quarterly), DON, Administrator, M. Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.  Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the new 4 weeks and thereafter once a month for the next 3 months.  Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include date.	QA IDS an  ext or  ates ed.	

PRINTED: 02/01/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 55.125			(		
		345390	B. WING _			12/	15/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US 158 EAST STOKESDALE, NC 27357				
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F 640	PM with the facility's interview, the Administrative aware of concerns reassessments being on the indicated resider had to assign the MD medication cart at time coordinator was work completed and caughindicated it was here assessments are constant of the indicated it was here assessments are constant of the indicated it was here assessments are constant of the indicated it was here assessments are constant of the indicated for Resident had discharged assisted living facility. MDS completed for Resident had discharged assisted living facility's lindicated she was be assessments, and was completed. She indicated the indicated the assessment indicated the assessment within 14 days from the An interview was conpleted. An interview was conpleted was conpleted indicated the assessment of the indicated the assessment	ducted on 12/15/22 at 4:30 Administrator. During the strator indicated she was garding the MDS verdue and not completed. It care was their priority and S coordinator to the es. She indicated the MDS ing to get the assessments it up. The Administrator expectation that the MDS ingleted timely.  admitted to the facility on  on dated 8/25/22 noted the led from the facility to an  There was no discharge desident #37.  ducted on 12/15/22 at 12:25 MDS Coordinator. She within in completing some to completed the discharge les working to get them lated she had been pulled ment to work on the lead fallen behind. She ments should be completed the discharge date.  ducted on 12/15/22 at 4:30 Administrator. During the strator indicated she was	F	640	completion of MDS discharge assessments are completed no later th 14 days after resident discharges. The committee consists of Medical Director (only quarterly), DON, Administrator, M Coordinator, Nursing Supervisor, Huma Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.  Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the ne 4 weeks and thereafter once a month fithe next 3 months.  Reports/Audits will be presented to the committee monthly by MDS Coordinator or Director of Nursing/Designee to ensicorrective action for trends or ongoing concerns is initiated as appropriate. Th QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursi Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) a other departmental managers.	QA IDS an ext or QA or ure e		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345390	B. WING			12/	15/2022
NAME OF P	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE 700 US 158 EAST TOKESDALE, NC 27357		
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F 640	had to assign the MD medication cart at tim coordinator was work completed and caugh indicated it was her e assessments are com	nt care was their priority and S coordinator to the les. She indicated the MDS ing to get the assessments at up. The Administrator expectation that the MDS		640 656			1/6/23
SS=D	S483.21(b) Comprehe §483.21(b) (1) The faci implement a compreheare plan for each resident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identifiassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2(ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized serehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside	ensive Care Plans cility must develop and nensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive inprehensive care plan must g- are 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 s.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. th the resident and the					110/23

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		345390	B. WING _		C 12/15/2022		
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 7700 US 158 EAST STOKESDALE, NC 27357		2/13/2022	
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F 656	F 656 Continued From page 11		F 6	56			
	(A) The resident's godesired outcomes.  (B) The resident's profuture discharge. Face whether the resident community was assellocal contact agencial entities, for this purposed in the purpose	als for admission and eference and potential for cilities must document s desire to return to the essed and any referrals to es and/or other appropriate ose. In the comprehensive care in accordance with the th in paragraph (c) of this ervices provided or arranged ined by the comprehensive epetent and trauma-informed. It is not met as evidenced riew and staff interviews the op a comprehensive care ents (Resident #219) e ulcers.		F656- Develop/Implement Comprehensive Care Plan  483.21- Comprehensive Car  The plan of correction is prey submitted solely because of of state and federal law. The made on this Plan of Correction and do not consider a state of the plan of correction and state Regulations the fataken or will take the actions this Plan of Correction. The I Correction constitutes the fatallegation of compliance such alleged deficiencies cited hawill be corrected by the date indicated. The plan of corrections	pared and requirements e statements tion are not constitute an deficiencies. all Federal acility has set forth in Plan of cility's th that all ve been or or dates		

PRINTED: 02/01/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
345390		B. WING	B. WING		C <b>12/15/2022</b>			
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE				77	TREET ADDRESS, CITY, STATE, ZIP CODE  700 US 158 EAST  TOKESDALE, NC 27357	<u>  12/</u>	15/2022	
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F 656			F	656	address the processes that lead to the deficiency cited.  Address how corrective action will be accomplished for those residents found have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  The facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident #219) reviewed for pressure ulcers.  After a review of the deficient practice, residents (Resident #219) were found thave been affected. After a thorough review, an audit was performed to other residents with a comprehensive MDS stating if resident is at risk for pressure ulcers to ensure it is appropriately care planned. To identify any other residents having the potential to be affected by the same deficient practice, no other residents were seen to be affected at the time.  After review of the deficient practice, education was conducted by Administrator/Designee on 1/2/2023 withe Administrator, Director of Nursing, and the potential to the practice, education was conducted by Administrator, Director of Nursing, and the process of the practice of the practice, education was conducted by Administrator, Director of Nursing, and the process of the practice of the practice, education was conducted by Administrator, Director of Nursing, and the practice of the practice	no to er s he his		
				MDS Coordinator, to develop and implement a comprehensive personcentered care plan for each resident, consistent with the resident rights set for and that includes measurable objective and timeframes to meet a residents				

Event ID: 1MKY11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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345390			B. WING _	B. WING			15/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COUNTRY	'SIDE				700 US 158 EAST		
OOOMINI	OIDL			S	TOKESDALE, NC 27357		
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F 656	Continued From page	e 13	F	356	medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  Address what measures will be put into place or systemic changes made to ensure what the deficient practice;  On 1/2/2022, education was conducted Administrator/Designee with the Administrator, Director of Nursing, MDS Coordinator, to develop and implement comprehensive person- centered care plan for each resident, consistent with the resident rights set forth and that include measurable objectives and timeframes meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  Administrator, Director of Nursing and MDS Coordinator will meet weekly to review and audit comprehensive care plans. An audit will be conducted to ensure completion of comprehensive person-centered care plan for each resident is consistent with the resident rights set forth and that includes measurable objectives and timeframes meet a residents medical, nursing, and mental and psychosocial needs that an identified in the comprehensive assessment.	to	
				On 1/3/2023, Administrator/Director of Nursing reviewed with QA team of wee	kly		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	ľ	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE			B. Wilde	STREET ADDRESS, CITY, STATE, ZIP C 7700 US 158 EAST STOKESDALE, NC 27357	I	12/15/2022	
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F 656	Continued From pag	e 14	F 6	meetings to ensure accurate completion of resident's concare plans. The QA commit Medical Director (only quar Administrator, MDS Coordi Supervisor, Human Resour Worker, Plant Operations Methodology of the departmental manage Weekly meetings between Administrator, Director of Methodology of Meetings between Administrator, Director of Meetings and thereafter one of the next 3 months.  Indicate how the facility platits performance to make sustained; and when corrective action will On 1/3/2023, Administrator Nursing reviewed with QA to meetings to ensure accurate completion of resident's concare plans. The QA commit Medical Director (only quar Administrator, MDS Coordi Supervisor, Human Resour Worker, Plant Operations Meetings between Administrator, Director of Meetings between Administrator, Director of Meetings Coordinator will be held weeks and thereafter once	mprehensive ttee consists terly), DON, nator, Nursin res.  the dursing, and eld for the next tee a month for the that deld for the sea and mprehensive ttee consists terly), DON, nator, Nursin rece, Social Manager, a quarterly) are res.	of g and  xt r ess d. dy of g and	

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		345390	B. WING		12/15/2022		
NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE				7	TREET ADDRESS, CITY, STATE, ZIP CODE  700 US 158 EAST		
				S	TOKESDALE, NC 27357		
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F 656	§483.35(b) Registerer §483.35(b)(1) Except paragraph (e) or (f) of must use the services least 8 consecutive he §483.35(b)(2) Except paragraph (e) or (f) of must designate a regidirector of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT by:  Based on record revifacility failed to have a	Full Time DON (3)  d nurse when waived under this section, the facility of a registered nurse for at ours a day, 7 days a week.  when waived under this section, the facility stered nurse to serve as the a full time basis.  ector of nursing may serve ly when the facility has an ncy of 60 or fewer residents. is not met as evidenced ew and staff interviews the a Registered Nurse (RN) ecutive hours a day for 1		727	the next 3 months.  Reports/Audits will be presented to the committee monthly by MDS Coordinate or Director of Nursing/Designee to ensicorrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursicon Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers  F727- RN 8 Hrs/7 days/Wk, Full Time DON  483.35: Registered Nurse	or ure ie	1/6/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345390		` '	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
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F 727	Continued From pa	ge 16	F 7	27	
	F 727 Continued From page 16 Findings included:  The daily nursing schedules from 11/12/22 through 12/12/22 were reviewed and revealed there was no registered nurse (RN) on 11/24/22.  Review of the timecards and RN scheduled staffing assignment sheets revealed the facility had no documentation of an RN present in the facility on 11/24/22 to meet the requirement for an RN at least 8 consecutive hours per day on each day.  During an interview conducted with the Administrator on 12/15/22 at 9:30 am she stated there should have been an RN scheduled every day. However, on Thanksgiving Day (11/24/22) no RN was present in the facility  An interview was conducted with Nurse #2 on 12/15/22 at 1:19 pm she indicated she was a RN and that she believed she worked on 11/24/22.  Review of Nurse #2's timecard for 11/24/22 indicated she did not work.  An interview was conducted with the Director of Nursing on 12/15/22 at 3:10 pm. She stated she expected the facility to have an RN staffed to meet the regulation for 8 consecutive hours a day, 7 days a week.  During an interview conducted with the Administrator on 11/15/22 at 3:30pm she stated she expected the Scheduler to staff an RN for 8 hours per day, 7 days a week.			The plan of correction is submitted solely because of state and federal law. made on this Plan of Coran admission to and do agreement with the alleg To remain incompliance and State Regulations that taken or will take the actithis Plan of Correction. To Correction constitutes thallegation of compliance alleged deficiencies cited will be corrected by the cindicated. The plan of cospecific deficiency. The paddress the processes the deficiency cited.	e of requirements The statements rrection are not not constitute an led deficiencies. with all Federal le facility has lions set forth in The Plan of le facility's such that all d have been or date or dates lorrecting the loan should
				Address how corrective a accomplished for those in have been affected by the practice; Address how the identify other residents in potential to be affected be deficient practice.  The facility failed to have Nurse (RN) scheduled for hours a day for 1 (11/24/reviewed.  After a review of the deficients were found to laffected. To identify any having the potential to be same deficient practice, residents were seen to be time.	residents found to the deficient the facility will the aving the the a Registered or 8 consecutive (22) of 30 days  cient practice, no thave been other residents the affected by the no other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345390	B. WING		C <b>12/15/2022</b>		
NAME OF PROVIDER OR SUPPLIER				SI	TREET ADDRESS, CITY, STATE, ZIP CODE	12/	15/2022
COUNTRY	SIDE				700 US 158 EAST TOKESDALE, NC 27357		
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F 727	Continued From page	÷ 17	F	727	After review of the deficient practice, education was completed on 12/16/202 with the Administrator, Director of Nursiand Scheduler, to ensure facility has 8 consecutive hours of RN coverage severages as week.  Address what measures will be put into place or systemic changes made to ensure what the deficient practice;  On 12/16/2022, education was conduct by Administrator/Designee with the Administrator, Director of Nursing, scheduler to ensure facility has 8 consecutive hours of RN coverage severages as week.  A daily audit has been implemented to ensure 8 consecutive hours of RN coverage for seven days a week. The audit will be completed by the schedule and Director of Nursing/Designee to ensure a double check.  On 12/20/2022, Administrator/Director of Nursing reviewed with QA team of daily audits to ensure 8 consecutive hours of RN coverage for seven days a week. To QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) a other departmental managers.	en ed en of fhe	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER  COUNTRYSIDE				STREET ADDRESS, CITY, STATE, ZIP CODE  7700 US 158 EAST  STOKESDALE, NC 27357			
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F 727	SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		F7	Indicate how the facility plar its performance to make sur solutions are sustained; and when corrective action will be On 12/20/2022, Administrate Nursing reviewed with QA to audit to ensure facility has 8 hours of RN coverage sever week. The QA committee committee committee committee of Medical Director (only quart Administrator, MDS Coordin Supervisor, Human Resourd Worker, Plant Operations M Pharmacy Consultant (only other departmental manage Daily meetings between the and Director of Nursing/Desheld for the next 4 weeks ar once a month for the next 3 Reports/Audits will be prese committee monthly by the D Nursing/Designee to ensure action for trends or ongoing initiated as appropriate. The committee consists of Medic (only quarterly), DON, Admi Coordinator, Nursing Super Resource, Social Worker, P Operations Manager, Pharm Consultant (only quarterly) adepartmental managers.	re that I Include dates be completed.  or/Director of eam of a daily consecutive n days a onsists of erly), DON, nator, Nursing ce, Social anager, quarterly) and rs.  Scheduler ignee will be nd thereafter months.  ented to the QA orector of e corrective concerns is e QA cal Director nistrator, MDS visor, Human lant nacy		