STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345390	A. BUILDING: _____ B. WING _____	4/18/2024

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the discharge status on a Minimum Data Set (MDS) Assessment for 1 of 1 resident reviewed for discharge (Resident #56). The findings included: Resident #56 was admitted to the facility on 2/23/24. Review of the discharge Minimum Data Set (MDS) Assessment dated 2/28/24 indicated Resident #56 was discharged to a general hospital. Review of a nursing note dated 2/28/24 indicated Resident #56 was discharged home with family. A telephone interview with the MDS Nurse on 2/18/24 at 11:28 am was conducted. She stated the discharge MDS for Resident #56 dated 2/28/24 should have been coded as discharged home. She explained she had inaccurately miscoded the MDS in error. An interview with the Director of Nursing (DON) on 4/18/24 at 1:00 pm revealed residents' discharge MDS should accurately reflect their discharge status. During an interview with the Administrator on 4/18/24 at 1:52 pm she indicated the MDS should be completed accurately.
F 867	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information

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

The above isolated deficiencies pose no actual harm to the residents

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from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described

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in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 12/15/22 recertification and complaint investigation. This was for 1 recited deficiency on the current recertification and complaint survey of 4/18/24 in accuracy of assessment (F641). The continued failure during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:
This tag is cross-referenced to:

F-641 Based on record review and staff interviews the facility failed to accurately code the discharge status on a Minimum Data Set (MDS) Assessment for 1 of 1 resident reviewed for discharge (Resident #56).

During the 12/15/22 recertification and complaint survey the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of discharge status for 1 of 4 discharged residents reviewed

Interview with the Administrator on 4/18/24 at 3:00 pm. The Administrator shared that QAA meetings were held monthly. And, that the facility had identified a concern with Quarterly Minimum Data sets (MDS) assessments and discharge assessments. As a result, the facility would monitor for a period of 12 weeks. This monitoring was completed on 1/1/24 with all assessments being current and up to date as of 11/6/23.