STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345390	A. BUILDING _____ B. WING _____	C 05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE	7700 US HIGHWAY 158 STOKESDALE, NC 27357

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/29/25 through 5/2/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # V9T511.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 4/29/25 through 5/2/25. Event ID# V9T511. The following intakes were investigated NC00227147 and NC00228039. 7 of 7 allegations did not result in a deficiency.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 641		5/8/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/23/2025

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F 641	Continued From page 1 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of respiratory care and active diagnosis for 2 of 14 residents reviewed for MDS accuracy (Residents #32 and #41). The findings included: 1. Resident #32 was admitted to the facility on 5/17/24 with diagnoses that included pneumonia. A record review indicated Resident #32 had a physician order dated 9/1/24 for oxygen via nasal canula at 2 liters per minute to maintain oxygen level of greater than 92%. A record review of Resident #32's February 2025 Medication Administration Record (MAR) revealed oxygen therapy was administered daily. The quarterly Minimum Data Set (MDS) assessment dated 2/24/25 did not indicate Resident #32 had received oxygen therapy. An interview was conducted on 5/1/25 at 3:39 PM with Minimum Data Set (MDS) Nurse #1. She stated it was an oversight that MDS Nurse #2 did not code the use of oxygen therapy in the Special	F 641	Address how corrective action will be accomplished for those residents found to 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 accurately code the Minimum Date Set (MDS) assessment in the areas of respiratory care and active diagnosis for 2 of 14 residents reviewed for MDS accuracy (Resident #32 and #41). The MDS assessment was corrected on resident #32 and #41 on 5/2/2025. After a thorough review, an audit was performed to all other residents. After a review of the deficient practice, 9 of 51 residents were found to have been affected in the areas of respiratory care and active diagnosis. To identify any other residents having the potential to be affected by the same deficient practice, 9 of 51 residents were corrected on 5/2/2025. After review of the deficient practice,	

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F 641	Continued From page 2 Treatments and Programs section of Resident #32's quarterly MDS assessment dated 2/24/25. An interview was conducted on 5/1/25 at 3:56 PM with the Director of Nursing. She stated she expected the MDS assessments to be coded accurately. 2. Resident #41 was admitted to the facility on 6/22/23 with a diagnosis that included anxiety disorder. A record review indicated Resident #41 had an active diagnosis of bipolar disorder since 7/3/23. A review of the Medication Administration Record from 3/18/25-3/24/25 revealed Resident #41 received antipsychotic medication daily for bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated 3/24/25 did not indicate Resident #41 had an active diagnosis of bipolar disorder in the Psychiatric/Mood Disorder section. An interview was conducted on 5/2/25 at 9:33 AM with Minimum Data Set (MDS) Nurse #1. She stated it was an oversight that the MDS Nurse #2 did not code an active diagnosis of bipolar disease in the Psychiatric/Mood Disorder section of Resident #41's quarterly MDS assessment dated 3/24/25. An interview was conducted on 03/06/25 at 10:50 AM with the Administrator. He stated she expected the MDS assessments to be coded accurately.	F 641	education was conducted by VP of MDS Services/Designee on 5/5/2025 with MDS Coordinator to review accuracy of MDS in the areas of respiratory care and active diagnosis. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 5/5/2025, education was conducted by VP of MDS Services/Designee with the MDS Coordinator to review accuracy of MDS in the areas of respiratory care and active diagnosis. Administrator, Director of Nursing and MDS Coordinator will meet weekly to review assessments and ARD to ensure accuracy of MDS in the areas of respiratory care and active diagnosis. On 5/8/2025, Administrator reviewed with QA team of weekly meetings to ensure accuracy of MDS in the areas of respiratory care and active diagnosis. The 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) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing and MDS Coordinator will be held for the next 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	

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F 641	Continued From page 3	F 641	solutions are sustained; and Include dates when corrective action will be completed. On 5/8/2025, Administrator reviewed with QA team of weekly meetings to ensure accuracy of MDS in the areas of respiratory care and active diagnosis. The 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) and other departmental manager. Weekly meetings between the Administrator, Director of Nursing and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Reports/Audits will be presented to the QA committee monthly by MDS Coordinator or Director of Nursing/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The 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) and other departmental managers. Completion date 5/8/2025.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		5/8/25

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F 656	Continued From page 4	F 656		

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 §483.24, §483.25 or §483.40 but are not provided 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 preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 5 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan in the area of respiratory care for 1 of 14 residents reviewed for comprehensive care plans (Resident #32). The findings included: Resident #32 was admitted to the facility on 5/17/24 with diagnosis that included pneumonia. A record review indicated Resident #32 had a physician order dated 9/1/24 for oxygen via nasal canula at 2 liters per minute to maintain oxygen level of greater than 92%. The quarterly Minimum Data Set (MDS) assessment dated 2/24/25 did not indicate Resident #32 had received oxygen therapy. A record review of Resident #32's February 2025 Medication Administration Record (MAR) revealed oxygen therapy was administered daily. Review of Resident #32's comprehensive care plan dated 2/27/25 did not reveal a care plan for respiratory care. On 4/29/25 at 11:12 AM, Resident #32 was observed in room in bed with the oxygen concentrator in use, but the oxygen tubing was not on Resident #32 who was observed to be coughing.	F 656	Address how corrective action will be accomplished for those residents found to 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 care plan in the area of respiratory care for 1 of 14 residents (Resident #32) reviewed for comprehensive care plans After a review of the deficient practice, no residents (Resident #32) were found to have been affected due to Medication Administration Record (MAR) revealed oxygen therapy was administered. On 5/1/2025, (Resident#32) care plan was immediately updated to reflect respiratory care. After a thorough review, an audit was performed to all other residents. To identify any other residents having the potential to be affected by the same deficient practice, 6 other residents were seen to be affected at this time. On 5/1/2025, all 6 care plans were updated to reflect respiratory care. After review of the deficient practice, education was conducted by VP of MDS Services/Designee on 5/5/2025 with the MDS Coordinator, to develop and implement a comprehensive person-	

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F 656	Continued From page 6 An interview was conducted with Nurse #1 on 4/30/35 at 3:05 PM. Nurse #1 indicated Resident #32 was known to remove her oxygen tubing from her nose and forget to replace it therefore nursing staff had to monitor and reposition the oxygen tubing as needed to ensure her oxygen saturation remained above 92%. An interview was conducted with MDS Nurse #1 on 5/1/25 at 3:39 PM and she indicated that Resident #32 should have had a care plan developed for respiratory care and that it was an oversight. An interview was conducted with the Director of Nursing on 5/1/25 at 4:05 PM and she indicated that Resident #32 should have had a care plan developed for respiratory care.	F 656	centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a resident medical, and nursing needs. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 5/5/2025, education was conducted by VP of MDS Services/Designee with the MDS Coordinator, to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a residents medical and nursing needs. 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 to meet a residents medical and nursing needs. On 5/8/2025, Administrator/Director of Nursing reviewed with QA team of weekly meetings to ensure accuracy and completion of residents comprehensive care plans. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social	

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F 656	Continued From page 7	F 656	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 next 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 dates when corrective action will be completed. On 5/8/2025, Administrator/Director of Nursing reviewed with QA team of weekly meetings to ensure accuracy and completion of residents comprehensive care plans. The 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) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Reports/Audits will be presented to the QA committee monthly by MDS Coordinator or Director of Nursing/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social	

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F 656	Continued From page 8	F 656	Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Completion date 5/8/2025.	