	-	ID HUMAN SERVICES				FOR	M APPROVED
		MEDICAID SERVICES					<u> </u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				E SURVEY PLETED
		345390	B. WING				C / 02/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	05	102/2023
					700 US HIGHWAY 158		
COUNTRY	/SIDE				STOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	investigation survey v through 5/2/25. The compliance with the r	equirement CFR 483.73, ness. Event ID # V9T511.	F	000			
	investigation survey v through 5/2/25. Even	certification and complaint vas conducted on 4/29/25 nt ID# V9T511. The e investigated NC00227147					
F 641 SS=D	Accuracy of Assessm		F	641			5/8/25
	§483.20(g) Accuracy The assessment mus resident's status.	of Assessments. t accurately reflect the					
	conduct or coordinate	ion. A registered nurse must e each assessment with the ion of health professionals.					
	certify that the assess §483.20(i)(2) Each in portion of the assess	ered nurse must sign and					
	individual who willfull (i) Certifies a material	ledicare and Medicaid, an					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electroni	cally Signed						05/23/2025

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	(X3) DATE SURVEY	-039			
AND PLAN OF	IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED				
			D M/NO	С				
345390			B. WING	05/02/2025	5			
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
COUNTRY	/SIDE			7700 US HIGHWAY 158 STOKESDALE, NC 27357				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ETION		
F 641	Continued From page	e 1	F 64					
1 011	penalty of not more th		1 04					
	assessment; or							
		ndividual 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 asse $8483,20(i)(2)$ Clinical	disagreement does not						
	constitute a material	-						
		Γ is not met as evidenced						
	by:							
		iew and staff interviews, the		Address how corrective action will				
	-	ately code the Minimum		accomplished for those residents for	ound to			
	. ,	essment in the areas of active diagnosis for 2 of 14		have been affected by the deficient practice; Address how the facility w				
		or MDS accuracy (Residents		identify other residents having the				
	#32 and #41).			potential to be affected by the same	•			
				deficient practice.				
	The findings included:							
	1. Resident #32 was admitted to the facility on			The facility failed to accurately code Minimum Date Set (MDS) assessm				
		es that included pneumonia.		the areas of respiratory care and ac				
	o, mil alagnoo			diagnosis for 2 of 14 residents revie				
	A record review indic	ated Resident #32 had a		for MDS accuracy (Resident #32 ar				
		d 9/1/24 for oxygen via nasal		#41). The MDS assessment was				
	canula at 2 liters per level of greater than 9	minute to maintain oxygen 92%.		corrected on resident #32 and #41 of 5/2/2025.	on			
	A record review of Re	esident #32's February 2025		After a thorough review, an audit wa	as			
	Medication Administra			performed to all other residents. Aft				
	revealed oxygen ther	apy was administered daily.		review of the deficient practice, 9 of	51			
	The quarterly Minimu	im Data Set (MDS)		residents were found to have been affected in the areas of respiratory of	are			
		24/25 did not indicate		and active diagnosis. To identify an				
		ceived oxygen therapy.		residents having the potential to be affected by the same deficient pract				
		ducted on 5/1/25 at 3:39 PM		of 51 residents were corrected on				
		Set (MDS) Nurse #1. She		5/2/2025.				
		sight that MDS Nurse #2 did		After review of the deficient are dis-				
	I not code the use of o	xygen therapy in the Special	1	After review of the deficient practice	L			

Facility ID: 923121

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 05/02/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US HIGHWAY 158 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 641 Continued From page 2 F 641 Treatments and Programs section of Resident education was conducted by VP of MDS #32's quarterly MDS assessment dated 2/24/25. Services/Designee on 5/5/2025 with MDS Coordinator to review accuracy of MDS in An interview was conducted on 5/1/25 at 3:56 PM the areas of respiratory care and active with the Director of Nursing. She stated she diagnosis. expected the MDS assessments to be coded accurately. Address what measures will be put into place or systemic changes made to 2. Resident #41 was admitted to the facility on ensure what the deficient practice; 6/22/23 with a diagnosis that included anxiety disorder. On 5/5/2025, education was conducted by VP of MDS Services/Designee with the A record review indicated Resident #41 had an MDS Coordinator to review accuracy of active diagnosis of bipolar disorder since 7/3/23. MDS in the areas of respiratory care and active diagnosis. Administrator, Director of A review of the Medication Administration Record Nursing and MDS Coordinator will meet from 3/18/25-3/24/25 revealed Resident #41 weekly to review assessments and ARD received antipsychotic medication daily for bipolar to ensure accuracy of MDS in the areas of disorder. respiratory care and active diagnosis. The quarterly Minimum Data Set (MDS) On 5/8/2025. Administrator reviewed with assessment dated 3/24/25 did not indicate QA team of weekly meetings to ensure accuracy of MDS in the areas of Resident #41 had an active diagnosis of bipolar disorder in the Psychiatric/Mood Disorder section. respiratory care and active diagnosis. The QA committee consists of Medical An interview was conducted on 5/2/25 at 9:33 AM Director (only quarterly), DON, with Minimum Data Set (MDS) Nurse #1. She Administrator, MDS Coordinator, Nursing stated it was an oversight that the MDS Nurse #2 Supervisor, Human Resource, Social did not code an active diagnosis of bipolar Worker, Plant Operations Manager, disease in the Psychiatric/Mood Disorder section Pharmacy Consultant (only quarterly) and of Resident #41's quarterly MDS assessment other departmental managers. dated 3/24/25. Weekly meetings between the Administrator, Director of Nursing and An interview was conducted on 03/06/25 at 10:50 MDS Coordinator will be held for the next 4 weeks and thereafter once a month for AM with the Administrator. He stated she expected the MDS assessments to be coded the next 3 months. accurately. Indicate how the facility plans to monitor its performance to make sure that

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923121

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	D. 0938-03 SURVEY
ND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER:	· ,	BUILDING		PLETED
			D. MILLO			С
		345390	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	05/02/2025	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US HIGHWAY 158		
COUNTRY	SIDE			STOKESDALE, NC 27357		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		OULD BE COMPLE	
	Continued From pag	Comprehensive Care Plan	F 64	solutions are sustained; and Include when corrective action will be comp On 5/8/2025, Administrator reviewe QA team of weekly meetings to ens accuracy of MDS in the areas of respiratory care and active diagnos QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, N Supervisor, Human Resource, Soci Worker, Plant Operations Manager Pharmacy Consultant (only quarter other departmental manager. Weekly meetings between the Administrator, Director of Nursing a MDS Coordinator will be held for th 4 weeks and thereafter once a more the next 3 months. Reports/Audits will be presented to committee monthly by MDS Coordi or Director of Nursing/Designee to corrective action for trends or ongo concerns is initiated as appropriate QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, N Supervisor, Human Resource, Soci Worker, Plant Operations Manager Pharmacy Consultant (only quarter other departmental managers.	oleted. ed with sure is. The ursing al (y) and nd e next th for the QA nator ensure ing . The ursing al	5/8/25
	§483.21(b) Compreh §483.21(b)(1) The fa	ensive Care Plans cility must develop and				

Facility ID: 923121

If continuation sheet Page 4 of 9

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 06/12/2025 MAPPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
345390			B. WING				C 05/02/2025		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CO	DDE			
COUNTRY				7700 US HIGHWAY 158					
COUNTRY	SIDE			S	TOKESDALE, NC 27357				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 656	implement a compreh care plan for each res resident rights set fort §483.10(c)(3), that inc objectives and timefra medical, nursing, and needs that are identifi assessment. The com describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that y under §483.24, §483. provided due to the re- under §483.10, includ treatment under §483 (iii) Any specialized se rehabilitative services provide as a result of recommendations. If a findings of the PASAF rationale in the resider (iv)In consultation with resident's representat (A) The resident's goa desired outcomes. (B) The resident's pre- future discharge. Faci whether the resident's community was asses local contact agencies entities, for this purpo (C) Discharge plans in plan, as appropriate, i	hensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ied in the comprehensive hprehensive care plan must d- the 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 6.10(c)(6). ervices or specialized the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)- als for admission and efference and potential for ilities must document is desire to return to the ssed and any referrals to s and/or other appropriate	F	656					

Facility ID: 923121

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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 05/02/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US HIGHWAY 158 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 656 Continued From page 5 F 656 §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 bv: Based on record review and staff interviews, the Address how corrective action will be facility failed to develop a care plan in the area of accomplished for those residents found to respiratory care for 1 of 14 residents reviewed for have been affected by the deficient comprehensive care plans (Resident #32). practice; Address how the facility will identify other residents having the The findings included: potential to be affected by the same deficient practice. Resident #32 was admitted to the facility on 5/17/24 with diagnosis that included pneumonia. The facility failed to develop a care plan in the area of respiratory care for 1 of 14 A record review indicated Resident #32 had a residents (Resident #32) reviewed for physician order dated 9/1/24 for oxygen via nasal comprehensive care plans canula at 2 liters per minute to maintain oxygen After a review of the deficient practice, no level of greater than 92%. residents (Resident #32) were found to have been affected due to Medication The quarterly Minimum Data Set (MDS) Administration Record (MAR) revealed assessment dated 2/24/25 did not indicate oxygen therapy was administered. On Resident #32 had received oxygen therapy. 5/1/2025, (Resident#32) care plan was immediately updated to reflect respiratory A record review of Resident #32's February 2025 care. After a thorough review, an audit was performed to all other residents. To Medication Administration Record (MAR) revealed oxygen therapy was administered daily. identify any other residents having the potential to be affected by the same deficient practice, 6 other residents were Review of Resident #32's comprehensive care plan dated 2/27/25 did not reveal a care plan for seen to be affected at this time. On respiratory care. 5/1/2025, all 6 care plans were updated to reflect respiratory care. On 4/29/25 at 11:12 AM, Resident #32 was observed in room in bed with the oxygen After review of the deficient practice, concentrator in use, but the oxygen tubing was education was conducted by VP of MDS not on Resident #32 who was observed to be Services/Designee on 5/5/2025 with the coughing. MDS Coordinator, to develop and implement a comprehensive person-

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

Event ID: V9T511

Facility ID: 923121

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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 05/02/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US HIGHWAY 158 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 656 Continued From page 6 F 656 An interview was conducted with Nurse #1 on centered care plan for each resident, consistent with the resident rights set forth 4/30/35 at 3:05 PM. Nurse #1 indicated Resident #32 was known to remove her oxygen tubing and that includes measurable objectives from her nose and forget to replace it therefore and timeframes to meet a resident nursing staff had to monitor and reposition the medical, and nursing needs. oxygen tubing as needed to ensure her oxygen saturation remained above 92%. Address what measures will be put into place or systemic changes made to An interview was conducted with MDS Nurse #1 ensure what the deficient practice; on 5/1/25 at 3:39 PM and she indicated that Resident #32 should have had a care plan On 5/5/2025, education was conducted by developed for respiratory care and that it was an VP of MDS Services/Designee with the oversight. MDS Coordinator, to develop and implement a comprehensive person-An interview was conducted with the Director of centered care plan for each resident, Nursing on 5/1/25 at 4:05 PM and she indicated consistent with the resident rights set forth that Resident #32 should have had a care plan and that includes measurable objectives developed for respiratory care. 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: V9T511

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/12/2025 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		345390	B. WING				02/2025
NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
COUNTR	COUNTRYSIDE				700 US HIGHWAY 158		
				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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	e 7	F	656	Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the r 4 weeks and thereafter once a month the next 3 months. Indicate how the facility plans to moni its performance to make sure that solutions are sustained; and Include of when corrective action will be complet On 5/8/2025, Administrator/Director of Nursing reviewed with QA team of we meetings to ensure accuracy and completion of residents comprehensive care plans. The QA committee consis Medical Director (only quarterly), DON Administrator, MDS Coordinator, Nurs Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the r 4 weeks and thereafter once a month the next 3 months. Reports/Audits will be presented to th committee monthly by MDS Coordina or Director of Nursing/Designee to en corrective action for trends or ongoing concerns is initiated as appropriate. T QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nurs Supervisor, Human Resource, Social	d hext for tor lates ted. of lekly re ts of l, sing and d hext for e QA tor sure he	

Event ID: V9T511

Facility ID: 923121

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		345390			C 05/02/2025	
	ROVIDER OR SUPPLIER	343330		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
				7700 US HIGHWAY 158 STOKESDALE, NC 27357		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 656	Continued From pag	ge 8	F 65			

Facility ID: 923121

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