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 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MANOR	7700 US 158 EAST 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
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility left a resident unattended in the shower and did not provide assistance with incontinent care when the resident required assistance and the facility was aware of these needs for 1 of 3 residents that needed assistance with activities of daily living (Resident #78). The findings included Resident #78 was admitted to the facility on 7/18/12. The diagnoses included rhabdomyolosis, varicose veins lower extremities, muscle weakness, lack of coordination and history of falls. The Minimum Data Set(MDS) dated 10/14/12 indicated that Resident #78 was alert and oriented with a brief interview mental status of 14 and able to make decisions regarding her care. The MDS also indicated that Resident #78 needed assistance with part of bathing/shower due to physical impairment of lower extremities, toileting, transfers and required one person assistance. Review of care plan dated 11/6/12 identified the problem as decline in activities physical	F 224	The following plan of correction is required by rules found in Title 42, Code of Federal Regulations and is submitted in order to remain in compliance with these rules and regulations, thus allowing residents who depend upon Medicare and Medicaid to continue to receive care here. This plan of correction is not an admission of lack of compliance with Federal requirements. Countryside Manor does not necessarily agree with all statements of fact or observations stated by the survey agency or attributed to interviews and reserves the right to appeal these findings, and submits the plan of correction prior to any appeals or review of facts, as required by regulation. F224 The facility updated its procedure on communicating resident rights to residents, responsible parties, and staff members. The facility counseled Nurse #2, Nurse #3, NA#2, and NA#5 reminding them of their obligation to implement facility policy and procedures that prohibit mistreatment, neglect, and abuse of residents, and misappropriation of resident property. Specific guidance was given as to how this specific resident experienced the events of 1/24/2013 and 1/26/2013 and how it may have violated facility policy and procedures related to resident dignity and choice, and the possibility of neglect. Nurse #1 is no longer an employee of the facility. The Director of Nursing met with resident #78 and reeducated her on resident rights and how to report instances of mistreatment, neglect, abuse, and misappropriation of property	2/19/2013 2/2/2013 2/20/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M.G. E. Stanley	Administrator	2-22-13

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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F 224	Continued From page 1 functioning requiring staff assistance with activities of daily living related to de-conditioning, need for assistance with activities of daily living and problems with anxiety sequencing. The goal included restoration of prior level of functioning. The approaches included allow for sufficient time to complete ADL task, required 1 person assistance with transfers, ambulation and toileting and provide as needed the supportive assistive devices to aid in self performance. 2 Risk for falls related to de-conditioning, difficulty maintaining standing balance, impaired balance during transfers. The goal included to remain free of falls and further injuries. The approaches included assistance with all transfers from bed, chair and toilet, administer medication as ordered by physician and encourage resident to seek assistance for transfers, toileting and ambulation. 3. Risk for functional urinary incontinence. The goal included would have no increase incontinence episodes. The approaches included help avoid frustration by assisting as necessary. During a resident interview on 1/29/2013 at 9:03AM, Resident #78 reported that last Thursday 1/24/13, she was taken to the shower room between 1:00PM-1:30PM and she was left in the shower room for an hour unattended. She was left unclothed (bottom area) by nursing assistant while the NA#2 went to do something else and she was cold freezing to death. She pulled the call light but could night remember how long it was when the staff left or when the charge nurse found her in the bathroom. She stated that "I felt terrible I was cold/freezing to death with no clothes, felt abandoned because I was so sick and tired of doing the shower and I could not get out of here (shower)." Resident #78 stated that	F 224	The facility will hold inservice training for all staff on what constitutes neglect, abuse, mistreatment, crimes against residents, injuries of unknown origin, and misappropriation of property, The facility will hold inservice training for all staff on the procedure for reporting abuse, neglect, mistreatment of residents, crimes against residents, injuries of unknown origin, and misappropriation of resident property. The Director of Nursing met with resident #78 to review her choices and update her plan of care. With the resident's input the facility changed her goals concerning her wound treatment after showering. (At the time of the survey it was understood by staff that the resident requested to remain in the shower and did not want to go back to her room until a dressing change had been done while still in the shower and before she was moved to her wheelchair. The resident was also insistent that nothing be put on the lower portion of her body or legs to prevent any contact with her wound.) Revised goals with input and consent of resident #78 are: "Resident chooses to have dressing changes in the shower immediately after her bath. Resident will receive treatment to her left ankle wound either upon completion of her bath, or if nurse is unable to provide immediate treatment, resident is to be assisted with dressing by staff and assisted back to her room with her wound securely covered and with call light within reach to comfortably await for nurse to provide treatment within a timely	2/28/2013 2/20/2013

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F 224	Continued From page 2 she had told the social worker who was across the hall and head nursing knew about it. Resident #78 stated she felt afraid of NA#2 that left her in the shower and that NA#2 treated her as though it was her way or no way. During an interview on 1/29/13 at 4:44PM, Nurse#2 indicated that she saw the light was on in the shower room on the front hall, when she went in she found Resident#78 in the shower area left unattended sitting on the shower bench with her top on and no clothing on the bottom. Nurse #2 indicated that she asked the resident if she needed assistance and resident responded she would be ok. Nurse stated she told the resident she would go get help and find somebody. Nurse #2 did not indicate the time frame she was in the shower room. Nurse#2 stated that she left the shower room and went to get the assigned NA. Nurse#2 did not indicate how long it was when she found Resident #78 in the bathroom. Nurse#2 stated that she did not know why she didn ' t help the resident when she found her in the shower room. Nurse#2 indicated that she did not return to the shower area once she asked the staff to return to the bathroom. During an interview on 1/29/13 at 8:48PM, NA#1 indicated that Resident #78 was unable to get out of the shower without assistance. Resident #78 generally received showers on 1st shift and she was given a shower between 1:00-2:00PM, but she was uncertain how long the resident was in the shower room. NA#1 acknowledged that Resident#78 should not have been left unattended and that the resident could not wash any part of her body beyond arms reach.	F 224	manner as ordered." Care plan for resident #78 was also updated to state "Resident to be provided stand by assist with toileting whether in bathroom or using bedpan while staff also maintains privacy and not to be left alone to ensure timely assistance, or if unable to remain with resident while on bedpan or in bathroom due to emergent situation, staff must place call light within reach while communicating with resident the intent to find another staff member, bring the staff member back to the resident making a formal introduction to stay with resident until the assigned staff member is able to return." The facility believes that all residents have the potential to be affected. It will conduct training as stated above to ensure that all residents are treated in a manner that prevents abuse, neglect, mistreatment and misappropriation of resident property. The facility will monitor for compliance and effectiveness of its program to prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property by periodic interviews of residents, periodic interviews of families or responsible parties, and periodic interviews of staff. Those interviews will be conducted monthly for one quarter, then quarterly. Each monthly sample will be collected from 10% of residents, 10% of residents' responsible parties or families, and 10% of staff. Resident #78 will be interviewed each month for the first 3 months to ensure satisfaction in the area of mistreatment, neglect, abuse, and the misappropriation of property. .	2/20/2013 Cont. 2/28/2013 Ongoing

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F 224	Continued From page 3 During an interview on 1/29/12 at 9:07PM, NA#2 indicated that she could not recall which day of the week the incident happen. She stated that Resident #78 needed one person assistance with all ADLS. Resident#78 scheduled shower day was Monday and Thursday. NA#2 indicated on the day of the incident it was late in the evening after lunch that she could get to the resident ' s shower. NA#2 added that she had given the resident a shower and afterward she went to tell Nurse#1 that Resident #78 was ready to get her dressing change on her foot. NA#2 stated she could not recall how long it was when she left or when Nurse#1 came to down to do the dressing change. NA#2 indicated when she went to report that Resident #78 was ready for the dressing change to Nurse #1 she also informed her co-worker that she was going on break and Resident #78 was in shower room waiting on Nurse#1. She went on break but could not remember how long she had been out in the break area before Nurse#2 came out and told her she needed to get the resident out of the bathroom because there was no nursing assistant ' s on the hall. NA#2 added that she returned to the bathroom alone and she did not know where Nurse#2 went after they left the break area. During an observation on 1/30/13 at 7:10AM, bathroom/shower area on front hall: included standard bathroom/shower area accessible for wheelchairs. The shower had a shower chair, grab bar and call light accessibility within reach from a seated position. During a follow-up interview on 1/30/13 at 7:26AM, Resident#78 restated that she usually	F 224	The Director of Social Services or her designee will conduct these interviews and report them to the administrator monthly and to the facility Quality Assurance Committee quarterly The facility Quality Assurance Committee will review findings of the interviews and surveys and make recommendations for changes in facility policy and procedure to ensure compliance and to ensure high customer satisfaction	ongoing

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F 224	Continued From page 4 finished lunch around 1:00PM to 1:30PM and she waited about an hour after the shower for the nurse to do the wound care. She stated that she could not leave the shower unless the wound care was done. Resident#78 also stated that she had a good night because the lady(NA#5) that made her feel bad and scared her did not work last night and hope that it was not just a one night flute. Observation of resident ' s room revealed a clock directly across from the bed. Resident stated that she used the bedpan around 6:00AM every morning. During an interview on 1/30/13 at 7:42AM, Nurse#1 indicated as the primary nurse who performed wound care for Resident#78. Nurse#1 stated that Resident #78 did require one person assistance with showers/baths, toileting and transfers. Typically the nursing assistants would let her know when they complete the shower and she would come and do the dressing change. Nurse#1 indicated that Resident#78 was very particular about whom did her wound care and the resident ' s preference was to have the dressing change after her shower. Nurse#1 indicated she was unable to recall how long the resident stated she was left in the bathroom or whether the resident was upset or afraid about staff treatment. Nurse#1 indicated that she could not recall which day of the incident but did the dressing change around 9:45AM, and had to page NA#2 back to shower room to dress the resident. Nurse #1 indicated that she was uncertain why she didn ' t dress Resident#78 after she did the dressing change. 2. Resident#78 also presented a hand written note undated that read (second incident). " NA#5	F 224		

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F 224	Continued From page 5	F 224		

is the name of the person on the 3rd shift who from what I hear is very mean to the residents. I asked her to put me on the bedpan and to leave the door wide open. It took me only a minute to use it. She closed the door and left me on the bedpan for 30 minutes, which was very painful. " Resident#78 stated that she was furious because she was in such pain and it didn ' t need to happen. Resident #78 indicated that the incident happen about a week ago (Thursday or Friday). Resident #78 stated that she was afraid NA#5 would come back soon and do something else. Resident #78 reported that she told Nurse #4 on second shift what happen with NA#5 and she had told various nursing assistants. Resident #78 further stated that staff has not gotten back to her for a response. Resident #78 also indicated that she spoke with director of social work about being left on the bed pan for 30 minutes. Resident stated she knew when she needed to use the bathroom and could wait up to an hour before she would received assistance, so she would go to the bathroom door to wait for staff coming down the hall for help. She used the bed pan at night.

During an interview on 1/29/13 at 4:30PM, the social worker (SW) indicated that Resident #78 spoke with her on 1/28/13, indicating that she had been placed on the bedpan and left for 30 minutes. SW reported the concern to the DON who had been investigating the issue. SW indicated the resident identified NA#5 on 3rd shift as the person who left her on the bed pan. SW added that the resident had given her a note indicating what happened, but it did not have a date of when she was left on the bed pan. SW added that she was unaware of the situation with the resident being left in the shower by staff.

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F 224	Continued From page 6 During an interview on 1/30/13 at 11:01AM, NA#5 indicated that Resident #78 used the call light at 4:30AM on 1/26/13, requesting the use of the bed pan.NA#5 indicated that she didn ' t close the door all the way to provide the resident with some privacy and she went to the assisted living side to monitor the residents while the assigned nursing assistant went on smoke break. She indicated that she was not gone more than five minutes and she had let the nursing assistant on the unit know that she was going over to assisted living. Na#5 indicated that the staff she left in charge was expected to answer any of the call lights while she was relieving the other nursing assistant. She added that Resident#78 did ask her to leave the door open, but she closed it and left it cracked, because she was told anytime a resident was on bed pan door should be closed for privacy. When she returned from the assisted living side, Resident#78 was upset with her and stated that she left her on the pan for 30 minutes and she got her off the bed pan. During an interview on 1/29/12 at 5:13PM, Nurse#3 indicated that she first became aware of Resident#78 had been left unattended in the shower/bathroom by NA #2 and Nurse#2 request for her to return to the shower/bathroom and attend to Resident #78. Nurse #3 later stated that Nurse #2 also came to her(between 2:00-2:30PM) an reported that Resident #78 was found in the bathroom unattended by her and NA#2 was the assigned staff. Nurse#3 added that Nurse#2 reported that when she saw the call light was on in the shower/bathroom on front hall, Nurse#2 went into bathroom and found Resident #78 alone in the shower area, she asked the	F 224		

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F 224	Continued From page 7	F 224		

resident if she was ok. Nurse#2 indicated that she left the resident unattended to find the assigned NA. Nurse #3 indicated she was uncertain why Nurse#2 did not assist Resident#78. Nurse#3 added that she was uncertain how long the resident was left unattended by either report from NA#2 or Nurse#2.

DON indicated that she was unware of the resident being left in the shower unattended and she did not investigate the situation as an allegation of abuse or neglect, because it had not been reported to her or the administrator in that manner. DON indicated that Nurse#3 reported the situation as a staff conflict in the morning meeting the following day. DON indicated that Resident #78 should not have been left unattended at anytime in the bathroom. The expectation would have been when Nurse #2 found Resident#78 in the bathroom assistance should have provided. Nurse #2 should have contacted the administrator/DON and follow the abuse policy/procedure. Nurse#3 also had the responsbility of contacting the administrator and/or DON when the issue was reported to her by NA#2 and Nurse#2. DON also acknowledged that Resident#78 had also reported to the SW on 1/28/13 that she had been left on the bedpan 30 minutes by NA#5 whom she requested not to close door and that the staff did not return. DON indicated that the SW had received a written note from Resident #78 describing the events and she had not completed the investigation nor had she spoken directly with resident about the events.

During an interview on 1/30/13 at 10:33AM, the administrator indicated that the incident with the resident in the shower room was the first time he

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F 224	Continued From page 8 had heard of this situation. Administrator indicated he was informed by Nurse#3 during a meeting that there was staff conflict and she had handled the situation. Administrator added that investigation would have been done differently had he been informed that Resident #78 was left unattended in the bathroom or a resident had not received incontinent care assistance. The expectation was that staff followed the facility policy/procedures for allegations of abuse/neglect in-service that was done a few weeks ago. He added the expectation was that Nurse#2 whom found the resident should have immediately provided assistance to Resident#78, called the administrator/DON. In addition, leaving a resident unattended an hour in the shower was " neglectful behavior and inappropriate. " The staff should have been separated from the resident, suspended pending investigation, documentation of events obtained, and 24 hour/5 day report completed and sent to the appropriate agencies. Administrator stated " I am appalled that a nursing assistant would leave a resident unattended at anytime. The two staff that had knowledge of the incident should have contacted the administrator and DON immediately. " He added how Resident#78 felt about the incident was very important and the situation would have been investigated differently had he been made aware of the details of the situation.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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F 225	Continued From page 9 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews, and record review the facility failed to investigate an allegation of a resident being left unattended in the bath/shower room while staff	F 225	F225 The facility completed and filed 24 hour and 5 day reports concerning two separate allegation of mistreatment or neglect of resident #78. The facility followed its procedure and conducted a thorough investigation of both allegations, completing 24 hour and 5 day reports that were sent to NCHCPR. The facility counseled Nurse #2, Nurse #3, Nurse#4 NA#2, and NA#5 reminding them of their obligation to implement facility policy and procedures regarding the reporting of allegations of mistreatment, abuse, neglect, crimes against residents, injuries of unknown origin, and misappropriation of resident property. Specific guidance was given as to how this specific resident's allegation should have been reported if the resident had alleged neglect or mistreatment. Resident #78 was reeducated on how to report allegations of mistreatment, neglect, abuse, crimes against residents, and misappropriation of resident property. The facility believes that all residents have the potential to be affected.	2/10/2013 2/6/2013 2/2/2013 2/20/2013

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F 225	Continued From page 10 went on break for 1 of 3 residents and incontinent care assistance upon request for (Resident #78) whom needed assistance with toileting. The facility also failed to submit a 24 hour report and a 5 day investigation report to the appropriate state agency for 1 of 3 residents (Resident #78). The findings included: Review of the policy/procedure titled " Abuse, neglect, misappropriation of property, crime against resident, facility reporting and investigation of " updated 1/2013, read in part: Staff, Resident, or visitor: Report immediately any allegation, knowledge, or suspicion of abuse, neglect, misappropriation of property, or injuries of unknown origin which appear to be caused by abuse or neglect, or reasonable suspicion of crimes against a resident to the Director of Nursing or Nurse On Call or Administrator immediately of any of the above incidents. Remove any threat or potential danger to resident by reassigning or suspending accused staff. Send 24 hour report to DFS/Healthcare Personnel Registry. Postmark or fax within 24 hours of alleged incident or 24 hours of notification of incident/ report (fax) to HCPR within 2 hours of event and becoming aware of event. Interview the person making report and record any and all information known. Take steps to prevent further abuse or neglect while investigation. This may involve conferring with an employee ' s supervisor about reassigning duties or temporary administrative leave. Assure that the resident ' s attending physician and responsible party have been notified of any incident resulting in injury according to " Accident Involving Resident " procedure. Conduct thorough investigation. Send	F 225	The facility will conduct inservice training for all staff regarding facility policy on mistreatment, abuse, neglect, crimes against residents, injuries of unknown origin, and misappropriation of resident property. Particular emphasis in this training will be on what constitutes mistreatment, neglect, abuse, injuries of unknown origin, crimes against residents, and misappropriation of resident property; when to report such incidents, to whom to report such incidents, and where to find copies of current facility procedures and forms. The facility will monitor for compliance and effectiveness of its procedure to report mistreatment, neglect, and abuse of residents and misappropriation of resident property by periodic interviews of residents, periodic interviews of families or responsible parties, and periodic interviews of staff. Those interviews will be conducted monthly for one quarter, then quarterly. Each monthly sample will be collected from 10% of residents, 10% of residents' responsible parties or families, and 10% of staff. Resident #78 will be interviewed each month for the first 3 months to ensure satisfaction in the area of mistreatment, neglect, abuse, and the misappropriation of property. The Director of Social Services or her designee will conduct these interviews and report them to the administrator monthly and to the facility Quality Assurance Committee quarterly. The Quality Assurance Director will review all surveys and ensure that 24 hour and 5 day reports are in place for each allegation or instance of abuse, neglect,	2/28/2013 Ongoing

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 01/31/2013

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F 225	Continued From page 11 5 day report and a written report within 5 business day of allegation or indicates to the following: DFS-complaints division/HCPR, Guilford Department of Social Services, NC Board of nursing. Maintain documentation on everything done in the investigation in the abuse/neglect/complaint file in administrator office. Resident #78 was admitted to the facility on 7/18/12. The diagnoses included rhabdomyolosis, varicose veins lower extremities, muscle weakness, lack of coordination and history of falls. The Minimum Data Set (MDS) dated 10/14/12 indicated that Resident #78 was alert and oriented with a brief interview mental status of 14 and able to make decisions regarding her care. The MDS also indicated that Resident #78 needed assistance with part of bathing/shower due to physical impairment of lower extremities, toileting, transfers and required one person assistance. During a resident interview on 1/29/2013 at 9:03AM, Resident #78 reported that last Thursday 1/24/13, she was taken to the shower room between 1:00PM-1:30PM and she was left in the shower room for an hour unattended. She was left unclothed (bottom area) by nursing assistant while the NA#2 went to do something else and she was cold freezing to death. She pulled the call light but could night remember how long it was when the staff left or when the charge nurse found her in the bathroom. She stated that "I felt terrible I was cold/freezing to death with no clothes, felt abandoned because I was so sick and tired of doing the shower and I could not get out of here (shower)." Resident #78 stated that	F 225	mistreatment, crimes against residents, injuries of unknown origin, and misappropriation of resident property The facility Quality Assurance Committee will review findings of the interviews and surveys and make recommendations for changes in facility policy and procedure to ensure compliance and to ensure high customer satisfaction.	Ongoing

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F 225	Continued From page 12 she had told the social worker who was across the hall and head nursing knew about it. Resident #78 stated she felt afraid of the NA#2 that left her in the shower and that NA#2 treated her as though it was her way or no way. During an interview on 1/29/13 at 4:44PM, Nurse#2 indicated that indicated that she did not return to the shower area once she asked the staff to return to the bathroom. She indicated that she did not do a body check or any other assessment of the resident to ensure there were no injuries or other problems. Nurse#2 stated an investigation was done by Nurse#3 and DON. Nurse #2 indicated that she gave verbal report to Nurse#3 about the incident and was not asked to write a statement or follow-up with the resident. She indicated that the DON asked what happened the next day. Staff was not sent home and continued to work with the resident. Nurse #2 indicated acknowledge that the administrator and director of nursing should have been contacted per training. Resident#78 also presented a hand written note undated that read (second incident). " NA#5 is the name of the person on the 3rd shift who from what I hear is very mean to the residents. I asked her to put me on the bedpan and to leave the door wide open. It took me only a minute to use it. She closed the door and left me on the bedpan for 30 minutes, which was very painful. " Resident#78 stated that she was furious because she was in such pain and it didn ' t need to happen. Resident #78 indicated that the incident happen about a week ago (Thursday or Friday). Resident #78 stated that she was afraid NA#5 would come back soon and do something else.	F 225		

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F 225	Continued From page 13 Resident #78 reported that she told Nurse #4 on second shift what happen with NA#5 and she had told various nursing assistants. Resident #78 further stated that staff has not gotten back to her for a response. Resident #78 also indicated that she spoke with director of social work about being left on the bed pan for 30 minutes. Resident stated she knew when she needed to use the bathroom and could wait up to an hour before she would received assistance, so she would go to the bathroom door to wait for staff coming down the hall for help. She used the bed pan at night. During an interview on 1/29/13 at 4:30PM, the social worker (SW) indicated that Resident #78 spoke with her on 1/28/13, indicating that she had been placed on the bedpan and left for 30 minutes. SW reported the concern to the DON who had been investigating the issue. SW indicated the resident identified NA#5 on 3rd shift as the person who left her on the bed pan. SW added that the resident had given her a note indicating what happened, but it did not have a date of when she was left on the bed pan. SW added that she was unaware of the situation with the resident being left in the shower by staff. SW further stated the administrator generally did the investigations and DON would conduct the investigation in his absence. The expectation would be the staff involved would not be assigned to the resident pending investigation results. During an interview on 1/30/13 at 11:01AM, NA#5 indicated that DON called her on 1/29/13 and asked her to come into facility at 9:00AM, she wrote her statement, but did not have a discussion with DON and she was informed she was suspended pending investigation.	F 225		

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F 225	Continued From page 14 During an interview on 1/29/12 at 5:13PM, Nurse#3 indicated that she did not speak with or check Resident#78 to see what happened after she had spoken with the two staff. Nurse #3 acknowledge that she had not contacted the administrator or DON per policy/procedure. DON indicated that she was unware of the resident being left in the shower unattended and she did not investigate the situation as an allegation of abuse or neglect, because it had not been reported to her or the administrator in that manner. The expectation would have been when Nurse #2 found Resident#78 in the bathroom assistance should have provided. Nurse #2 should have contacted the administrator/DON and follow the abuse policy/procedure. Nurse#3 also had the responsbility of contacting the administrator and/or DON when the issue was reported to her by NA#2 and Nurse#2. DON indicated the investigation should have started immediately once the resident was found by the nurse. DON confirmed that the facility policy/procedures were not followed which would have included the obtaining documentation(written statements) of the events, interviewing the resident, protection of the resident, staff suspension pending results of investigation, reporting process to state agencies. DON also acknowledged that Resident#78 had also reported to the SW on 1/28/13 that she had been left on the bedpan 30 minutes by NA#5 whom she requested not to close door and that the staff did not return. DON indicated that the SW had received a written note from Resident #78 describing the events and she had not completed the investigation nor had she spoken	F 225		

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F 225	Continued From page 15 directly with resident about the events. During a follow-up interview on 1/29/13 at 6:30PM, the DON stated that she did not have the witness statements from NA#1 or NA#2 nor did she do 24 hr or 5 day report in accordance with the facility policy and procedures for allegations of abuse/neglect in either incident. During an interview on 1/30/13 at 7:42AM, Nurse#1 indicated that she was not asked about the resident being left unattended in the bathroom, nor did she write a statement. During an interview on 1/30/13 at 10:33AM, the administrator indicated that the investigation would have been done differently had he been informed that Resident #78 was left unattended in the bathroom or a resident had not received incontinent care assistance. The expectation was that staff followed the facility policy/procedures for allegations of abuse/neglect. He added the expectation was that Nurse#2 whom found the resident should have immediately provided assistance to Resident#78, called the administrator/DON. In addition, leaving a resident unattended an hour in the shower was " neglectful behavior and inappropriate. " The staff should have been separated from the resident, suspended pending investigation, documentation of events obtained, and 24 hour/5 day report completed and sent to the appropriate agencies. The two staff that had knowledge of the incident should have contacted the administrator and DON immediately. "	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 16 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, record review, and facility policy review the facility failed to implement their policies and procedures to report, investigate, and protect 1 of 3 residents from alleged neglect (Resident #78). Review of the policy/procedure titled " Abuse, neglect, misappropriation of property, crime against resident, facility reporting and investigation of " updated 1/2013: Staff, Resident, or visitor: The Reporting process for any allegation, knowledge, or suspicion of abuse, neglect was not identified by facility staff. The investigation process of thoroughly investigating and completion of the Send 24 hour report to DFS/Healthcare Personnel Registry within 24 hours of alleged incident or 24 hours of notification of incident and the completion of the 5 day report and a written report within 5 business day of allegation had not been done. The protection process included removing any threat or potential danger to resident by reassigning or suspending accused staff. Take steps to prevent further abuse or neglect while investigation. This may involve conferring with an employee ' s supervisor about reassigning duties or temporary administrative leave. Assure that the resident ' s attending physician and responsible party have been notified of any incident resulting in injury	F 226	F226 The facility completed and filed 24 hour and 5 day reports concerning two separate allegation of mistreatment or neglect of resident #78. The facility followed its procedure and conducted a thorough investigation of both allegations, completing 24 hour and 5 day reports that were sent to NCHCPR. The facility counseled Nurse #2, Nurse #3, Nurse#4 NA#2, and NA#5 reminding them of their obligation to implement facility policy and procedures regarding the reporting of allegations of mistreatment, abuse, neglect, crimes against residents, injuries of unknown origin, and misappropriation of resident property. Specific guidance was given as to how this specific resident's allegation should have been reported if the resident had alleged neglect or mistreatment. Resident #78 was reeducated on how to report allegations of mistreatment, neglect, abuse, crimes against residents, and misappropriation of resident property. The facility believes that all residents have the potential to be affected. .	2/10/2013 2/6/2013 2/2/2013 2/20/2013

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F 226	Continued From page 17 according to " Accident Involving Resident " procedure. During an interview on 1/29/13 at 4:30PM, the social worker (SW) indicated that Resident #78 spoke with her on 1/28/13, indicating that she had been placed on the bedpan and left for 30 minutes. SW reported the concern to the DON who had been investigating the issue. SW indicated the resident identified NA#5 on 3rd shift as the person who left her on the bed pan. SW added that the resident had given her a note indicating what happened, but it did not have a date of when she was left on the bed pan. SW added that she was unaware of the situation with the resident being left in the shower by staff. SW further stated the administrator generally did the investigations and DON would conduct the investigation in his absence. The expectation would be the staff involved would not be assigned to the resident pending investigation results. During an interview on 1/29/13 at 4:44PM, Nurse#2 stated an investigation was done by Nurse#3 and DON. Nurse #2 indicated that she gave verbal report to Nurse#3 about the incident and was not asked to write a statement or follow-up with the resident. She indicated that the DON asked what happened the next day. Staff was not sent home and continued to work with the resident and acknowledge that the administrator and director of nursing should have been contacted per training. During an interview on 1/29/13 at 5:13PM, the DON indicated that she was unware of the resident being left in the shower unattended and she did not investigate the situation as an	F 226	The facility will conduct inservice training for all staff regarding facility policy on mistreatment, abuse, neglect, crimes against residents, injuries of unknown origin, and misappropriation of resident property. Particular emphasis in this training will be on what constitutes mistreatment, neglect, abuse, injuries of unknown origin, crimes against residents, and misappropriation of resident property; when to report such incidents, to whom to report such incidents, and where to find copies of current facility procedures and forms. The facility will monitor for compliance and effectiveness of its procedure to report mistreatment, neglect, and abuse of residents and misappropriation of resident property by periodic interviews of residents, periodic interviews of families or responsible parties, and periodic interviews of staff. Those interviews will be conducted monthly for one quarter, then quarterly. Each monthly sample will be collected from 10% of residents, 10% of residents' responsible parties or families, and 10% of staff. Resident #78 will be interviewed each month for the first 3 months to ensure satisfaction in the area of mistreatment, neglect, abuse, and the misappropriation of property. The Director of Social Services or her designee will conduct these interviews and report them to the administrator monthly and to the facility Quality Assurance Committee quarterly. The Quality Assurance Director will review all surveys and ensure that 24 hour and 5 day reports are in place for each allegation or instance of abuse, neglect, mistreatment,	2/28/2013 Ongoing

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F 226	Continued From page 18 allegation of abuse or neglect, because it had not been reported to her or the administrator in that manner. During an interview on 1/29/12 at 9:07PM, NA#2 indicated that she returned to the bathroom alone and she did not know where Nurse#2 went after they left the break area. NA#2 indicated that she had reported to Nurse#3 about the interaction and Resident #78 did not appear upset or voice any concerns. She added that she completed the care and returned the resident to her room. NA indicated that she completed her shift and had worked with Resident #78 since then. NA further stated that she spoke with the director of nursing the following day and informed her of the interaction with Nurse#2 which included the request for her to return to the shower area because the resident was left unattended and there were no nursing assistants on the hall. She added that she did not write anything down regarding the events of the evening and she was not told she could not work with Resident#78. During an interview on 1/30/13 at 10:33AM, the administrator indicated that investigation would have been done differently had he been informed that Resident #78 was left unattended in the bathroom or a resident had not received incontinent care assistance. The expectation was that staff followed the facility policy/procedures for allegations of abuse/neglect. He added the expectation was that the staff should have been separated from the resident, suspended pending investigation, documentation of events obtained, 24 hour/5 day report completed and sent to the appropriate agencies.	F 226	crimes against residents, injuries of unknown origin, and misappropriation of resident property. The facility Quality Assurance Committee will review findings of the interviews and surveys and make recommendations for changes in facility policy and procedure to ensure compliance and to ensure high customer satisfaction.	ongoing

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F 226	Continued From page 19 During a follow-up interview on 1/30/13 at 2:00PM, the DON presented the 24 hour initial report and statements that were obtained from NA#1, NA#2, NA#5 and Nurse#3 there were no other statements presented and the 5 day report had not been completed.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to maintain resident dignity shower and incontinent care for 1 of 3 residents that required assistance with activities of daily living(Resident #78). The findings included: Resident #78 was admitted to the facility on 7/18/12. The diagnoses included rhabdomylosis, varicose veins lower extremities, muscle weakness, lack of coordination and history of falls. The Minimum Data Set(MDS) dated 10/14/12 indicated that Resident #78 was alert and oriented with a brief interview mental status of 14 and able to make decisions regarding her care. The MDS also indicated that Resident #78 needed assistance with part of bathing/shower due to physical impairment of lower extremities, toileting, transfers and required one person assistance.	F 241		

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F 241	Continued From page 20 Review of care plan dated 11/6/12 identified the problem as decline in activities physical functioning requiring staff assistance with activities of daily living related to de-conditioning, need for assistance with activities of daily living and problems with anxiety sequencing. The goal included restoration of prior level of functioning. The approaches included allow for sufficient time to complete ADL task, required 1 person assistance with transfers, ambulation and toileting and provide as needed the supportive assistive devices to aid in self performance. 2 Risk for falls related to de-conditioning, difficulty maintaining standing balance, impaired balance during transfers. The goal included to remain free of falls and further injuries. The approaches included assistance with all transfers from bed, chair and toilet, administer medication as ordered by physician and encourage resident to seek assistance for transfers, toileting and ambulation. 3. Risk for functional urinary incontinence. The goal included would have no increase incontinence episodes. The approaches included help avoid frustration by assisting as necessary. During a resident interview on 1/29/2013 at 9:03AM, Resident #78 reported that last Thursday 1/24/13, she was taken to the shower room between 1:00PM-1:30PM and she was left in the shower room for an hour unattended. She was left unclothed (bottom area) by nursing assistant while the NA#2 went to do something else and she was cold freezing to death. She pulled the call light but could night remember how long it was when the staff left or when the charge nurse found her in the bathroom. She stated that "I felt terrible I was cold/freezing to death with no clothes, felt abandoned because I was so sick	F 241	F241 The Director of Nursing met with resident #78 to review her choices and update her plan of care. With the resident's input the facility changed her goals concerning her wound treatment after showering. (At the time of the survey it was understood by staff that the resident requested to remain in the shower and did not want to go back to her room until a dressing change had been done while still in the shower and before she was moved to her wheelchair. The resident was also insistent that nothing be put on the lower portion of her body or legs to prevent any contact with her wound.) Her revised goals with input and consent of resident #78 are: "Resident chooses to have dressing changes in the shower immediately after her bath. Resident will receive treatment to her left ankle wound either upon completion of her bath, or if nurse is unable to provide immediate treatment, resident is to be assisted with dressing by staff and assisted back to her room with her wound securely covered and with call light within reach to comfortably await for nurse to provide treatment within a timely manner as ordered." Care plan for resident #78 was also updated to state "Resident to be provided stand by assist with toileting whether in bathroom or using bedpan while staff also maintains privacy and not to be left alone to ensure timely assistance, or if unable to remain with resident while on bedpan or in bathroom due to emergent situation, staff must place call light within reach while communicating with resident the intent to find another staff member, Bring the staff member back to the resident making a formal introduction to stay with resident until the assigned staff member is able to return.	2/20/2013 2/20/2013 2/20/2013

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F 241	Continued From page 21 and tired of doing the shower and I could not get out of here (shower)." Resident #78 stated that she had told the social worker who was across the hall and head nursing knew about it. Resident #78 stated she felt afraid of the NA#2 that left her in the shower and that NA#2 treated her as though it was her way or no way. During an interview on 1/29/13 at 4:44PM, Nurse#2 indicated that she saw the light was on in the shower room on the front hall, when she went in she found Resident#78 in the shower area left unattended. Resident #78 was found sitting on the shower bench, resident had her top and no clothing on the bottom. Nurse#2 stated that she left the shower room and went to get the assigned NA. Nurse#2 stated that she did not know why she didn ' t help the resident when she found her in the shower room. Resident#78 did not tell her how she felt or how long she had been in the shower room. Nurse#2 indicated that she did not return to the shower area once she asked the staff to return to the bathroom. She indicated that she did not do a body check or any other assessment of the resident to ensure there were no injuries or other problems. Resident#78 also presented a hand written note undated that read (second incident). " NA#5 is the name of the person on the 3rd shift who from what I hear is very mean to the residents. I asked her to put me on the bedpan and to leave the door wide open. It took me only a minute to use it. She closed the door and left me on the bedpan for 30 minutes, which was very painful. " Resident#78 stated that she was furious because she was in such pain and it didn ' t need to happen. Resident #78 indicated that the incident	F 241	The facility counseled Nurse #2, Nurse #3, Nurse#4 NA#2, and NA#5 reminding them of their obligation to safeguard resident dignity and choice. Specific guidance was given as to how this specific resident's choice should be followed and how to reconcile when she desires to remain in the bath, but her wound treatment cannot be done immediately. Resident #78's care plan was updated to communicate these changes. Resident #78 was reeducated on how to request assistance If her desires have been misunderstood by staff. The facility believes that all residents have the potential to be affected. The facility will conduct inservice training for all staff regarding facility policy resident rights, specifically on choice and dignity. All staff will be educated on facility policy regarding resident rights.	2/2/2013 2/20/2013 2/20/2013 2/28/2013

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 01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MANOR	7700 US 158 EAST 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
F 241	Continued From page 22 happen about a week ago (Thursday or Friday). Resident #78 stated that she was afraid NA#5 would come back soon and do something else. Resident #78 reported that she told Nurse #4 on second shift what happen with NA#5 and she had told various nursing assistants. Resident #78 further stated that staff has not gotten back to her for a response. Resident #78 also indicated that she spoke with director of social work about being left on the bed pan for 30 minutes. Resident stated she knew when she needed to use the bathroom and could wait up to an hour before she would received assistance, so she would go to the bathroom door to wait for staff coming down the hall for help. She used the bed pan at night. During an interview on 1/29/13 at 4:30PM, the social worker (SW) indicated that Resident #78 spoke with her on 1/28/13, indicating that she had been placed on the bedpan and left for 30 minutes. SW reported the concern to the DON who had been investigating the issue. SW indicated the resident identified NA#5 on 3rd shift as the person who left her on the bed pan. SW added that the resident had given her a note indicating what happened, but it did not have a date of when she was left on the bed pan. SW stated that resident did not report how she felt or go into details only stating that she didn ' t want it to reoccur. SW added that she was unaware of the situation with the resident being left in the shower by staff. SW further stated the administrator generally did the investigations and DON would conduct the investigation in his absence. The expectation would be the staff involved would not be assigned to the resident pending investigation results.	F 241	The facility will monitor for compliance and effectiveness of its procedure to ensure dignity and respect of individuality by periodic interviews of residents, periodic interviews of families or responsible parties, and periodic interviews of staff. Those interviews will be conducted monthly for one quarter, then quarterly. Each interview sample will be collected from 10% of residents, 10% of residents' responsible parties or families, and 10% of staff. Resident #78 will be interviewed each month for the first 3 months to ensure satisfaction in the area of dignity and respect for individuality. The Director of Social Services or her designee will conduct these interviews and report them to the administrator monthly and to the facility Quality Assurance Committee quarterly. The facility Quality Assurance Committee will review findings of the interviews and surveys and make recommendations for changes in facility policy and procedure to ensure compliance and to ensure high customer satisfaction.	Ongoing Ongoing

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F 241	Continued From page 23 During an interview on 1/30/13 at 11:01AM, NA#5 indicated that Resident #78 used the call light at 4:30AM on 1/26/13, requesting the use of the bed pan.NA#5 indicated that she didn ' t close the door all the way to provide the resident with some privacy and she went to the assisted living side to monitor the residents while the assigned nursing assistant went on smoke break. She indicated that she was not gone more than five minutes and she had let the nursing assistant on the unit know that she was going over to assisted living. Na#5 indicated that the staff she left in charge was expected to answer any of the call lights while she was relieving the other nursing assistant. She added that Resident#78 did ask her to leave the door open, but she closed it and left it cracked, because she was told anytime a resident was on bed pan door should be closed for privacy. When she returned from the assisted living side, Resident#78 was upset with her and stated that she left her on the pan for 30 minutes and she got her off the bed pan and the resident did not report that she was in any pain. NA#5 indicated that she returned to Resident#78 ' s room around 6:00AM, to put her in the wheelchair and there was no further discussion. NA#5 indicated that DON called her on 1/29/13 and asked her to come into facility at 9:00AM, she wrote her statement, but did not have a discussion with DON and she was informed she was suspended pending investigation. During an interview on 1/29/12 at 5:13PM, Nurse#3 indicated that she did not speak with or check Resident#78 to see what happened after she had spoken with the two staff. Nurse #3 acknowledge that she had not contacted the administrator or DON per policy/procedure.	F 241		

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F 241	Continued From page 24 DON indicated that she was unware of the resident being left in the shower unattended and she did not investigate the situation as an allegation of abuse or neglect, because it had not been reported to her or the administrator in that manner. DON indicated that Resident #78 should not have been left unattended at anytime in the bathroom. DON added that she later spoke with Resident#78 after she had spoken with the staff and verbally appologized to the resident for staff behavior. DON also acknowledged that Resident#78 had also reported to the SW on 1/28/13 that she had been left on the bedpan 30 minutes by NA#5 whom she requested not to close door and that the staff did not return. DON indicated that the SW had received a written note from Resident #78 describing the events and she had not completed the investigation nor had she spoken directly with resident about the events. During an interview on 1/29/12 at 9:07PM, NA#2 indicated that she had given the resident a shower and afterward she went to tell Nurse#1 that Resident #78 was ready to get her dressing change on her foot. NA#2 stated she could not recall how long it was when she left or when Nurse#1 came to down to do the dressing change. She went on break but could not remember how long she had been out in the break area. During a follow-up interview on 1/30/13 at 7:26AM, Resident#78 restated that she usually finished lunch around 1:00PM to 1:30PM and she waited about an hour after the shower for the nurse to do the wound care. She stated that she could not leave the shower unless the wound	F 241		

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F 241	Continued From page 25 care was done. Resident#78 also stated that she had a good night because the lady(NA#5) that made her feel bad and scared her did not work last night and hope that it was not just a one night flute. During an interview on 1/30/13 at 10:33AM, the administrator indicated that investigation would have been done differently had he been informed that Resident #78 was left unattended in the bathroom or a resident had not received incontinent care assistance. In addition, leaving a resident unattended an hour in the shower was " neglectful behavior and inappropriate. " Administrator stated " I am appalled that a nursing assistant would leave a resident unattended at anytime. The two staff that had knowledge of the incident should have contacted the administrator and DON immediately. " He added how Resident#78 felt about the incident was very important and the situation would have been investigated differently had he been made aware of the details of the situation.	F 241		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a medication error rate less than 5% as evidenced by 4 errors out of 63 opportunities for error, resulting in an error rate of 6.3% for 2 of 11	F 332		

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F 332	Continued From page 26 residents observed during medication pass (Residents #33, #95). Findings included: 1a. Resident #95 was admitted to the facility on 1/22/13 with multiple diagnoses including gastro-esophageal reflux disease (GERD) and cervical spondylosis. Review of the resident ' s clinical record revealed physician orders dated 1/22/13 for Ibuprofen 200mg (milligram) twice daily. Ibuprofen is a non-steroidal anti-inflammatory drug (NSAID) indicated for the treatment of pain and inflammation. Lexicomp's Drug Information Handbook, 14th edition, stated in part: Warnings/Precautions - NSAIDs may increase the risk of gastrointestinal irritation, ulceration, bleeding, and perforation. Use with caution with a history of GI (gastro-intestinal) disease and in elderly or debilitated patients. The elderly are at increased risk for adverse effects from NSAIDs even at low doses. Administration - administer with food. Observation of medication pass on 1/31/13 at 10:08AM revealed Nurse #1 administered twelve medications including one ibuprofen 200mg tablet. The nurse did not administer the ibuprofen with food. In an interview on 1/31/13 at 1:40PM, Nurse #1 stated she was trained periodically at nursing meetings in the facility. She was trained on proper administration of medications, which included giving medications correctly with regards to meals. The pharmacist had observed her administering medications for the first time about one week ago. A facility nurse had also observed her one other time since her hire. Nurse #1	F 332	F33 Resident #95 was monitored x 24hr for evidence of GI irritation upon notification of exit interview with Surveyor. Assessment revealed per staff interview, resident interview, and observation that Resident #95 remained free of signs and symptoms Gi irritation after receiving ordered Ibuporfen and metformin since having not received these medication with food, monitor for s/s of hypotension since not having received Coreg with food. Resident 33 was monitored and interviewed upon notification of medication error by Surveyor. Assessment revealed per staff interview, resident interview, and observation that Resident #33 remained free of s/s of experiencing Reflux since not having received Omeprazole on an empty stomach . Medication error report completed. Pharmacy consultant and MD notified. 332- The facility counseled Nurse #1 regarding medication administration, times, and preventing errors. Nurse#1 is no longer employed by facility.	2/01/2013 2/1/2013 2/2/2013

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F 332	Continued From page 27 stated ibuprofen should be given with the meal because it was a GI irritant. The nurse acknowledged she did not give the ibuprofen with food. She stated the breakfast trays were served at 7:45AM. Nurse #1 stated she usually gave the ibuprofen with the meal but "was running way behind today." In an interview on 1/31/13 at 6:27PM, the Director of Nursing (DON) stated the staff was trained to give medications at the correct time with regards to meals. The pharmacist completed med pass observations at least once per month. The Staff Development Coordinator conducted med pass observations when the staff was hired. She expected the staff to observe the five rights of medication administration - right medication, patient, dose, route, and time. Her expectation was for the medication error rate to be below 5%. 1b. Resident #95 was admitted to the facility on 1/22/13 with multiple diagnoses including diabetes and gastro-esophageal reflux disease (GERD). Review of the resident's clinical record revealed physician orders dated 1/22/13 for Metformin 1000mg twice daily with meals. Metformin is indicated for the treatment of diabetes. Lexicomp's Drug Information Handbook, 14th edition, stated in part: metformin may cause GI upset, take with food to decrease GI upset. Observation of medication pass on 1/31/13 at 10:08AM revealed Nurse #1 administered twelve medications including one metformin 1000mg tablet. The nurse did not administer the metformin with a meal.	F 332	Since all residents could be affected by the med error rate, the facility will continue ongoing training of all new licensed nursing staff and update orientation requirements which shows validation of knowledge of The five 'rights" of medication administration (See Exhibit 1). The facility will provide inservice education to all licensed nursing staff on the five rights of medication administration also with written validation of knowledge of the five rights of medication administration with special review of meds requiring to be given with food or meds given on empty stomach, Procedure for changing medication time of administration with regard to meals will be presented by a Consultant Pharmacist on or before 2/28/2013. The facility will inservice all licensed nursing staff on Medication Pass Technique and Medication Pass Sequence on or before 2/28/2013, The facility's Staff Development Coordinator (SDC) will continue Medication Pass Observation and validation with all new employees to ensure demonstration of less than 5% error rate.	2/28/2013 2/28/2013 2/28/2013 2/28/2013 Ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 332	Continued From page 28 In an interview on 1/31/13 at 1:40PM, Nurse #1 stated she was trained periodically at nursing meetings in the facility. She was trained on proper administration of medications, which included giving medications correctly with regards to meals. The pharmacist had observed her administering medications for the first time about one week ago. A facility nurse had also observed her one other time since her hire. Nurse #1 stated metformin should be given with the meal because it was a GI irritant. The nurse acknowledged she did not give the metformin with the meal. She stated the breakfast trays were served at 7:45AM. Nurse #1 stated she usually gave metformin with the meal but "was running way behind today." In an interview on 1/31/13 at 6:27PM, the Director of Nursing (DON) stated the staff was trained to give medications at the correct time with regards to meals. The pharmacist completed med pass observations at least once per month. The Staff Development Coordinator conducted med pass observations when the staff was hired. She expected the staff to observe the five rights of medication administration - right medication, patient, dose, route, and time. Her expectation was for the medication error rate to be below 5%. 1c. Resident #95 was admitted to the facility on 1/22/13 with multiple diagnoses including hypertension and myocardial infarction. Review of the resident's clinical record revealed physician orders dated 1/22/13 for Coreg 12.5mg twice daily with meals. Coreg is indicated for the treatment of hypertension and left ventricular dysfunction following myocardial infarction.	F 332	The facility's SDC will perform at least annual observation and validation on all licensed staff responsible for this task and random Medication Pass Observations (ongoing) by SDC. The facility Pharmacy Consultant (nurse/pharmacist) will perform 3 random Medication Pass Observations quarterly (ongoing). QA Director will perform quarterly audits to ensure facility is in compliance. Quality Assurance Committee will review findings and make changes as needed to ensure facility maintains Medication error rate of less than 5%.	Ongoing

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F 332	Continued From page 29 Lexicomp's Drug Information Handbook, 14th edition, stated in part: Coreg - Administration - administer with food. Should be taken with food to minimize the risk of orthostatic hypotension. Observation of medication pass on 1/31/13 at 10:08AM revealed Nurse #1 administered twelve medications including one Coreg 12.5mg tablet. The nurse did not administer Coreg with a meal. In an interview on 1/31/13 at 1:40PM, Nurse #1 stated she was trained periodically at nursing meetings in the facility. She was trained on proper administration of medications, which included giving medications correctly with regards to meals. The pharmacist had observed her administering medications for the first time about one week ago. A facility nurse had also observed her one other time since her hire. Nurse #1 stated Coreg should be given with the meal because it was a GI irritant. The nurse acknowledged she did not give the Coreg with the meal. She stated the breakfast trays were served at 7:45AM. Nurse #1 stated she usually gave Coreg with the meal but "was running way behind today." In an interview on 1/31/13 at 6:27PM, the Director of Nursing (DON) stated the staff was trained to give medications at the correct time with regards to meals. The pharmacist completed med pass observations at least once per month. The Staff Development Coordinator conducted med pass observations when the staff was hired. She expected the staff to observe the five rights of medication administration - right medication, patient, dose, route, and time. Her expectation	F 332		

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F 332	Continued From page 30 was for the medication error rate to be below 5%. 2. Resident #33 was admitted to the facility on 11/10/10 with multiple diagnoses including erosive esophagitis, gastritis, gastroduodenitis, and upper GI bleed. Review of the resident's clinical record revealed physician orders dated 1/22/13 for Omeprazole 20mg two capsules daily on an empty stomach. Omeprazole is a proton pump inhibitor indicated for the treatment of gastro-esophageal reflux disease (GERD) and treatment and maintenance of erosive esophagitis. Lexicomp's Drug Information Handbook, 14th edition, stated in part: Omeprazole - Administration - should be taken on an empty stomach; best if taken before breakfast. Observation of medication pass on 1/30/13 at 9:17AM revealed Nurse #1 administered six medications including two omeprazole 20mg capsules. Observation revealed the resident had just finished eating breakfast. Review of the resident's January 2013 medication administration record revealed omeprazole was scheduled to be given at 7:30AM. In an interview on 1/31/13 at 1:40PM, Nurse #1 stated she was trained periodically at nursing meetings in the facility. She was trained on proper administration of medications, which included giving medications correctly with regards to meals. The pharmacist had observed her administering medications for the first time about one week ago. A facility nurse had also observed her one other time since her hire. The nurse	F 332		

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F 332	Continued From page 31 acknowledged she did not give the omeprazole before breakfast. She stated the breakfast trays were served at 7:45AM. Nurse #1 stated omeprazole worked better if it was given before the meal. She usually gave omeprazole before the meal but "was running behind today." In an interview on 1/31/13 at 6:27PM, the Director of Nursing (DON) stated the staff was trained to give medications at the correct time with regards to meals. The pharmacist completed med pass observations at least once per month. The Staff Development Coordinator conducted med pass observations when the staff was hired. She expected the staff to observe the five rights of medication administration - right medication, patient, dose, route, and time. Her expectation was for the medication error rate to be below 5%.	F 332		

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345390	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing and 2000 New Health Care section of the LSC and its referenced publications. Building 0103 and 0203 is Type II construction, one story, with a complete automatic sprinkler system. Building 0303 is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/19/13 at approximately noon the following smoke barrier was non-compliant, specific findings include; The smoke wall located near the dining room had a gap in the wall at the I-beam.	K 025	\K025 The facility sealed around the metal beams with mineral wool. The facility believes that all residents were potentially affected by the penetrations in the walls. The Plant Operations Manager or designee will inspect all smoke walls for penetrations and seal them. The Plant Operations Manager will select one area each quarter for review of penetrations in smoke walls and report to the facility's quality assurance committee. The facility's quality assurance committee will review reports from the Plant Operations Manager and make recommendations to facility policies and procedures quarterly.	2/19/2013 3/26/2013 Ongoing Ongoing
K 045	NFPA 101 LIFE SAFETY CODE STANDARD	K 045	K045 The facility added a light to the emergency circuit in the activity room. The Plant Operations Manager or designee will inspect all rooms to ensure that at least one light remains on in all egress areas and will conduct audits quarterly to ensure compliance. The facility's quality assurance committee will review reports from the Plant Operations Manager and make recommendations to facility policies and procedures quarterly.	2/20/2013 2/26/2013 And ongoing Ongoing

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

3-8-13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345390	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MANOR	7700 US 158 EAST 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
K 045 SS=D	Continued From page 1 Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/19/13 at approximately noon the following egress illumination was non-compliant, specific findings include; the activity room would leave a patient in darkness.	K 045	K050 The facility conducted three fire drills, one on each shift, to ensure immediate compliance. The facility will report future fire drills and results to the quality assurance committee at least quarterly. The facility quality assurance committee will review the fire drill reports and results for compliance and make recommendations for improvements in the fire response efforts or in the operation of the fire drill procedure.	2/25/2013 Ongoing Ongoing
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By documentation on 2/19/13 at approximately noon the fire drills were non-compliant, specific findings include; documentation indicated less than the required number of drills were held on third shift of 2nd and 4th quarters of 2012, and	K 050		

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	345390	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/19/2013

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

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K 050	Continued From page 2 second shift of 1st and 3rd quarter 2012.	K 050		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 2/19/13 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant, specific findings include; The HVAC system did not shut down with fire alarm activation.	K 067	K067 The facility's HVAC Zone 3 shut down switch was repaired by an outside contractor starting 2/20/2013 and completed by 2/28/2013. The facility's fire drill procedure will be updated to review the operation of the shut off switches in the designated dill area or zone. The facility plant operations manager or designee will report the results of the fire drill and shut off operation to the facility quality assurance committee quarterly. The facility quality assurance committee will make recommendations for improvements in the fire drill procedure or equipment used in shutting off ventilation when reports show a problem.	2/28/2013 Ongoing Ongoing

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	345390	A. BUILDING 02 - BUILDING 02 B. WING _____	02/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE MANOR	7700 US 158 EAST 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
K 000	INITIAL COMMENTS There were no life safety code deficiencies noted at time of survey.	K 000		

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

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DPJ

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	345390	A. BUILDING 03 - SOUTH ADDITION - PRIM/ B. WING _____	02/19/2013

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

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K 000	INITIAL COMMENTS There were no life safety code deficiencies noted at time of survey.	K 000		

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SRS