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 _____	03/17/2016

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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain housekeeping and maintenance services to provide A. Clean floors and clean window ledge. B. Intact cove molding and window blinds on 1 (one) of 4 (four) resident care units. (Guilford). Findings included: A. Observation on 03/14/2016 at 5:20 PM revealed in the sitting area revealed an accumulation of dust on the window ledge. In the TV room there was an accumulation of dust and white particles on the window ledge. Observation on 03/15/2016 at 8:48 AM revealed the accumulation of dust remained on the window ledge. In the sitting room behind the green chair was a cluster of dust and brown colored particles. Under the green chair was a partially eaten lollipop stuck to the floor covered with 2 clusters of dust. There was an accumulation of a black colored substance in the floor corners of the sitting room. In the TV room there continued an accumulation of dust and white particles in the corner ledge of the window. Observation on 03/16/2016 at 8:25 AM revealed the condition of the sitting room and TV room was unchanged. Observation on 03/16/2016 8:33:00 AM revealed	F 253	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 agree with all statements of fact or observations stated by the survey agency 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. 1.) Interventions for affected resident: No residents were identified as being affected. 1. A deep cleaning of the sitting area on Guilford Hall was completed on March 16, 2016. The floors were buffed and cleaned in the sitting area, living area and dining area during the nightshift of March 16, 2016. Baseboards were stripped of floor wax build up on March 17, 2016.	4/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/01/2016

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 _____	03/17/2016

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 253	Continued From page 1 the partially eaten lollipop continued to be stuck to the floor with 2 clusters of dust on the surface, the accumulation of dust and brown colored particles and the accumulation of a black colored substance in the floor corners of the sitting room remained. B. Observation on 03/14/2016 at 5:20 PM revealed in the sitting area revealed one of the blind from the window blinds was missing. Observation on 03/15/2016 8:48 AM revealed cove molding was partially separated from the wall base behind the green chair in the sitting room. Observation on 03/16/2016 at 8:25 AM revealed in the sitting room had (2) holes in the window screen. One measured approximately 2 inches by 2 inches. The second screen hole measured 2 inches in length. Observation on 03/16/2016 at 8:30 AM revealed the missing blind from the window in the sitting room remained. Observation on 03/16/2016 at 8:33 AM revealed the cove molding continued to be partially separated from the wall base in the sitting room. Observation on 3/16/16 at 3:50 PM revealed the environmental conditions were unchanged. Observation on 3/16/16 at 3:57 PM of the environmental conditions with the administrator was performed. Interview via the phone on 03/17/2016 at 8:20	F 253	The window screens with holes on Guilford Hall were replaced on March 17, 2016. 2) Interventions for residents identified as having potential to be affected: All resident sitting/day areas were inspected on March 17, 2016. There were no other areas in the building found to have dust and/or lollipops under the furnishings. All window screens for the entire building were examined on March 17, 2016 and one small hole was found and patched on the Front Hall. 3.) Systemic Change The Plant Operations Manager met with the Housekeeping Supervisor to review the deep cleaning schedule for all areas of the building and expectation of daily cleaning for all living/sitting areas. Effective March 18, 2016, the night shift floor tech will be responsible for cleaning of the sitting, living and dining area of Guilford Hall on a nightly basis when the said areas are unoccupied. Effective March 21, 2016, window screen assessments were added to the housekeepers daily checklist list. Plant Maintenance will also complete a window screen assessment during the regular exterior window cleaning.	

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 _____	03/17/2016

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 253	Continued From page 2 AM with Housekeeper #1 (HK) (staff member who worked on the unit) stated she dry mopped and wet mopped the floors even under the green chair on 3/16/16. HK #1 stated she was unable to remember if she cleaned the window ledges. Interview on 03/17/2016 at 8:24 AM with the HK supervisor indicated HK staff should dust the window ledge, sweep under chairs and clean floor corners daily. Interview on 03/17/2016 at 8:34 AM with the Plant Operations Manager (who oversees housekeeping and maintenance services) stated the resident areas should be kept clean and in good repair.	F 253	4.) Monitoring of the change to sustain system compliance ongoing: The Housekeeping Supervisor and/or the Plant Operation Manager will perform daily audits of the Guilford Hall sitting, living and dining areas on a daily basis. The QA Director or designee will perform weekly audits of the sitting, living and dining areas on Guilford Hall for 3 months and report the results of audits to the QA Committee. The QA Committee will discuss and review the results to ensure compliance is sustained ongoing. Suggestions and recommendations will be made as needed by the QA Committee.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		4/5/16

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 _____	03/17/2016

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 278	Continued From page 3 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the dental status for 1 of 1 resident (Resident #65) reviewed for dental accuracy of the MDS. Findings included: Resident #65 was admitted to the facility on 10/30/2014 with cumulative diagnoses which included severe dementia. Record review revealed the resident was admitted with no natural teeth. Observation of the resident on 3/14/16 at 5:40 PM and 3/15/16 at 1:39 PM revealed Resident #65 was edentulous (no natural teeth). Review of the annual MDS assessment dated 10/8/2015 and the quarterly assessment dated 1/11/16 under Section L. Oral status revealed a check mark was entered to code " none of the above. " The MDS coordinator had a choice to check letter (B) to code Resident #65 as having " no natural teeth or tooth fragment(s) edentulous. "	F 278	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 agree with all statements of fact or observations stated by the survey agency 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. 1.) Interventions for affected resident: No residents were identified as being affected. 1. Resident #65□s MDS was corrected on 3/18/16 to include appropriate dentation in	

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 _____	03/17/2016

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 278	Continued From page 4 Interview on 03/17/2016 at 11:29 AM with the MDS coordinator revealed it was an omission in the coding and no other explanation was provided.	F 278	section L of the MDS. Corrected MDS has been transmitted to CMS. 2) Interventions for residents identified as having potential to be affected: On 03/18/2016, the MDS Nurse completed a 100% audit of all resident dentation assessments. On 04/05/2016, the Unit Manager reviewed all dentation assessments to check for accurate coding. There was one other coding error identified in Section L. The MDS for that resident was corrected, submitted and accepted for dates 01/15/2015 and 01/11/2016 on 04/05/2016. No harm occurred as the resident's plan of care and his diet correctly reflected the appropriate dentation and care measures. Oral/dental status will be added to MDS as appropriate in Section L of the MDS assessments per Medicare/Medicaid guidelines. 3.) Systemic Change The MDS Nurse has been will be in-serviced by the Director of Nursing regarding coding of correct Oral/Dental status in section L of the MDS. Any newly hired MDS Nurses will also be in-serviced regarding coding of Oral/Dental status in section L of the MDS. The Director of Nursing or Designee will audit 10 completed MDS assessments	

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 _____	03/17/2016

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 278	Continued From page 5	F 278	each month for the next 3 months to ensure coding of Oral/Dental status for correctness. The contracted Medical Records Consultant will audit 20% or 12 MDS assessments quarterly. The Medical Records Consultant reports will reflect the results of the audit and will be submitted to the QA Director. 4.) Monitoring of the change to sustain system compliance ongoing: The Quality Assurance Committee will discuss and review the results of the MDS Coding of Section L audits for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		4/1/16

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 _____	03/17/2016

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 329	Continued From page 6 given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to monitor blood values as ordered by the physician for one of one resident reviewed on anticoagulant therapy (Resident # 69). The findings included: Resident #69 was admitted on 11/16/15 with diagnoses of dementia and a history of deep vein thrombosis and pulmonary embolism. Resident #69 ' s admission Minimum Data Set (MDS) dated 11/23/15 revealed the resident was severely cognitively impaired. The resident was on anticoagulant and diuretic medications. Resident # 69 had physician orders dated 1/5/16 for Coumadin (an anticoagulant medication) 3 milligrams (mgs) to be given by mouth every Monday, Wednesday and Friday and for 4 mg to be given by mouth every Tuesday, Thursday, Saturday and Sunday. Resident #69 also had orders dated 11/24/15 through 3/31/16 for blood tests PT and INR to be completed every Monday. As documented on Labtestonline website, Prothrombin Time (PT) and International Normalized Ratio (INR) are blood tests used to	F 329	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 agree with all statements of fact or observations stated by the survey agency 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. 1.) Interventions for affected resident: PT/INR was obtained for resident #69 on 03/17/2016 and results called to the physician. No change was warranted in medication and the resident was not at risk for harm.	

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 _____	03/17/2016

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 329	Continued From page 7 monitor the effectiveness of the anticoagulant Warfarin (Coumadin). This drug affects the function of the coagulation cascade and helps inhibit the formation of blood clots. Resident #69 ' s care plan dated 2/22/16 for falls related to anticoagulant therapy. The interventions included to " monitor INR/PT as ordered, monitor for excessive bleeding and notify physician of abnormal PT/INR " . Review of the resident ' s medical record revealed on Monday 3/7/16 and Monday 3/14/16, the resident had no reports indicating a PT and INR was done. The last PT and INR was done on 2/29/16. The Medication Administration Record (MAR) was reviewed for February and March, 2015. All medications were given as ordered. Nurse #1 was interviewed on 3/16/16 at 1:41 PM. She stated there were orders for the resident to get his PT and INR drawn every Monday. He was getting INR/PT drawn every Monday but was not sure where the most recent labs results were. The last PT and INR were from 2/29/16. The Unit Manager was interviewed on 3/16/16 at 1:50 PM. She stated the order for PT/INR blood tests to be drawn every Monday had not been discontinued. The ordered should be written in a calendar at the nursing station then it should be transcribed to the lab book. She stated that any nurse can record in the calendar the blood tests that needed to be completed and then transcribe to the lab book. The Unit Manager looked through the calendar and stated that the PT/INR for Resident #69 were not in the calendar for the past two Mondays. In an additional interview on 3/16/16 at 2:00 PM, Nurse #1 confirmed there was no lab slip in the lab book for 3/7/16 and 3/14/16 indicating the PT/INR had been obtained.	F 329	2) Interventions for residents identified as having potential to be affected: An audit was conducted of all residents on anti-coagulant therapy that warranted lab review. There were no other missed labs identified. The Director of Nursing reviewed the current laboratory process and discovered areas that could be improved with the implementation of a revised process to improve the clinical outcomes for all residents. 3.) Systemic Change 1. Revision of the Laboratory process for all ordered labs for nursing staff with education in process to be provided to all licensed nursing staff by the Director of Nursing and the Staff Development/Quality Assurance Nurse. 2. All new hire nursing personnel will receive training on the revised laboratory process during their orientation. 3. Process to be implemented immediately upon completion of education of all licensed nursing personnel. The Unit Manager is currently monitoring labs on a daily basis. 4. Standing orders for all Laboratory Monitoring of Medications will remain in effect as the same.	

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 _____	03/17/2016

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 329	Continued From page 8 The physician was called on 3/16/16 at 1:55 PM by the Unit Manager. She informed the physician the labs were not drawn and got a telephone order for the PT and INR to be drawn tomorrow and to call him with results. The Blood test results dated 3/17/16 revealed resident #69 INR was 2.4 and PT was 25.8. The resident ' s INR was at a therapeutic level. An observation of Resident # 69 was made on 3/17/16 at 9:02 AM. The resident was sleeping in bed. There were no signs of bruising or bleeding. The Administrator was interviewed on 3/17/16 at 2:34 PM. She stated her expectation was for the nurse to verify the order with the MD and clarify any questions, the order was transcribed as ordered by the physician and the laboratory work was followed through. The Administrator also expected the physician was notified when the lab result was available. .	F 329	Revised Laboratory Order Process: " Each unit will have a Lab Log specifically for their unit to log lab orders as they are received. " The nurse will enter the order date of Lab, the resident's Name, the Lab to be ordered with the Date that the Lab is due to be drawn and the nurse will Initial when the order is obtained for the Lab. " Once the Lab is drawn, a nurse will enter the Date (which should match the date the Lab was due to be drawn)the lab was drawn and their Initial. " Once results are received the nurse will enter the Date and time of results and their Initial. " The Nurse will complete the Log entry for the Lab by documenting that the results are on the Chart or have been Faxed to MD and will document with their Initial. In addition to the revised Laboratory Order Process, all Lab orders will be placed on the Medication Record (MARS) when received. The established practice of placing the Labs that are due on specific dates will continue to be placed on the daily calendar that is located at each nursing station in the facility. 4.) Monitoring of the change to sustain system compliance ongoing: The Unit Manager will be responsible for doing weekly audits of the new lab process of all residents that have scheduled Laboratory testing. Results of the audits will be reported to the DON	

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 _____	03/17/2016

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 329	Continued From page 9	F 329	weekly and submitted to the QA Committee for review. The contracted pharmacy provider will assist in providing a list of those residents that require Laboratory follow up for prescribed medications on a weekly basis. This list will be given to the Director of Nursing and the Unit Manager to assist with the weekly audit. The pharmacy consultant will also assist with monitoring of laboratory testing during her regular monthly audits. Results of pharmacy audits will be reported to the DON as completed and submitted to the QA Committee for review. The Quality Assurance Committee will discuss and review the results of the Laboratory process audits monthly for a minimum of three months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing. The Unit Manager will be responsible for on-going monthly audits once the QA Committee deems the process is working appropriately.	