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 04/25/2018

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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		5/22/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/16/2018

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.

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 04/25/2018

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 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to create a care plan addressing the use of antidepressant medication for 1 of 5 residents with an active diagnosis of depression (Resident #13). Findings included: Resident #13 was admitted to the facility on 10/16/17 with the diagnoses including dementia, anxiety and major depression disorder. Resident's #13 Quarterly Minimum Data Set (MDS) dated 2/13/18 revealed the resident was severely cognitively impaired. The resident was on an anti-anxiety, anti-depressant, and opioid medication. The resident had a care plan last updated 10/25/17 addressing her use of anti-anxiety medications related to the diagnosis of anxiety disorder. The resident did not have a care plan in place to reflect her diagnosis depression or use of antidepressant medication. Review of physician's orders for 4/2018 revealed Resident #13 was receiving 20 milligrams of Citalopram daily (an anti-depressant medication). A nursing note dated 4/12/18 revealed the resident was crying intermittently throughout the shift. Nurse #2 was interviewed on 4/25/18 at 12:35	F 656	F656- Develop/Implement Comprehensive Care Plan The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to create a care plan addressing the use of antidepressant medication for 1 of 5 residents (Resident #13) with an active diagnosis. On 4/25/18, the MDS Nurse updated Resident #13's care plan to reflect the anti-depressant medication and the active diagnosis. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 5/09/18, the MDS Nurse, RN Supervisor and Director of Nursing reviewed all care plans for residents receiving anti-depressants with an active diagnosis. All current residents as of	

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 04/25/2018

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 656	Continued From page 2 PM. She stated the resident cried a lot and the resident did not know why. She stated the resident also had dementia and that the resident was sad a lot. The MDS nurse was interviewed on 4/25/18 at 1:27 PM. She stated that the resident had a diagnosis of dementia without behaviors, major depression disorder and anxiety. The res was getting Xanax (a medication for anxiety), Ativan (a medication for anxiety), and Citalopram (a medication for depression). She stated the resident had frequent episodes of depression and crying. She stated that she tried to update the care plan anytime things were added with the comprehensive and quarterly MDS assessments. She stated that she checked the mediations list and knew when a new medication was added and she would try to update the care plan for it. On the resident's last Admission MDS dated 10/23/17, the resident only was on an anti-anxiety and opioid medication. She stated the care plan was just not updated after the quarterly MDS was completed. On the Care Area Assessment (CAA) for the resident's admission assessment, it stated that the resident had depression and periods of crying. She stated she would have been the person that would have created the care plan for the resident and she had wrote about it in the CAA. She stated there was not a specific reason why her care plan did not reflect the anti-depressant medication. The Director of Nursing stated on 4/25/18 at 2:03 PM that the care plan was usually updated every 30 days and the care plan was based on her admission assessment. If a resident had a change in status then they would update the care plan as they go along.	F 656	5/13/18 with an order for antidepressants and an active diagnosis were noted to have a care plan addressing the use of antidepressants. As a result of the audit, there were no more identified residents needing care plan updates. The MDS Nurse was educated by the Director of Nursing on 5/09/18 regarding the development of a comprehensive person-centered care plan for each resident to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: services that are to be furnished to maintain the resident's highest practicable physical, mental, and psychosocial wellbeing as required under 483.24, 483.25 or 483.40. This would include the use of antidepressants for an active diagnosis. The care plan must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This education will also be included in the orientation of any new MDS Nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Administrator will conduct a review using the Care Plan Audit Tool: Antidepressants	

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 04/25/2018

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 656	Continued From page 3 The Director of Nursing stated on 4/25/18 at 2:40 PM that they updated the resident's care plan today to reflect the anti-depressant medication.	F 656	to ensure the care plans are up to date and addressing the use antidepressants and the active diagnosis when applicable. The review will include auditing 5 resident care plans a week for 4 weeks and then 5 resident care plans a month for 2 months. Identified issues will be addressed with appropriate action. Reports will be presented to the QA committee by the Administrator and/or Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Therapy, Health Information Manager (HIM), and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing and/or Administrator Date of Compliance: May 22nd, 2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		5/22/18

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 04/25/2018

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 657

Continued From page 4

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to update a care plan to reflect changes in the locomotion and transfer abilities of 1 of 4 residents reviewed for Activities of Daily Living (Resident #49).

Findings included:

Resident #49 was admitted to the facility on 4/4/18 with the diagnoses of muscle weakness, past joint replacement, and asthma.

Resident #49's Minimum Data Set (MDS) dated 4/11/18 revealed the resident was cognitively intact. The resident required limited assistance with bed mobility, transfers, walking in the room, locomotion, dressing, and toilet use. The resident required supervision with personal hygiene. The resident had lower extremities impairment on one side and used a wheelchair.

The resident had a care plan, updated 4/15/18, in place for Activities of Daily Living (ADL's). The

F 657

F657- Care Plan Timing and Revision
The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.
The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited;
The facility failed to update a care plan to reflect the changes in locomotion and transfer abilities of 1 of 4 residents (Resident #14).
The care plan for Resident #14 was not updated to address locomotion and

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 04/25/2018

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 657	Continued From page 5 ADL care plan stated that for locomotion and transfers, the resident required 1 -2 person assistance with the use of a walker and gait belt. Nursing Assistant #1 was interviewed on 4/24/18 at 10:52 AM. She stated the resident was alert and oriented. The resident only required supervision and could walk to the bathroom and was independent using the walker and getting to the bathroom. Nurse #1 was interviewed on 4/24/18 at 11:07 AM. She stated that Resident #49 was alert and oriented with confusion at times. She stated the resident was pretty much independent and could walk on her own in the hall and to the bathroom. Resident #49 was observed on 4/24/18 at 3:15 PM. The resident was observed walking in the hall independently with her walker. No concerns were noted. Nurse #2 was interviewed on 4/25/18 at 12:39 PM. She stated that the resident walked with her walker and could get to the bathroom on her own. She also stated that therapy had discharged the resident and she was able to walk on her own. The resident had a gait belt to help with walking when she first came and used it until about a week ago. The Assistant Physical Therapist was interviewed on 4/25/18 at 1:08 PM. She stated the resident needed assistance when she first came in. She stated that the resident was independent getting to the bathroom, dressing, bathing and walking in the hall with a walker. When the resident first came in, the resident used a gait belt. She also stated the Minimum Data Set nurse would update	F 657	transfer abilities on Resident #14 due to being discharged home on 4/25/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; On 5/10/18, the MDS Nurse, RN Supervisor and Director of Nursing reviewed all care plans for current residents to ensure care plans included accurate information regarding locomotion and transfer abilities. All necessary updates to care plans were completed by 5/15/18. The MDS Nurse was educated by the Director of Nursing on 5/09/18 regarding the development of a comprehensive person-centered care plan for each resident to include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: services that are to be furnished to maintain the resident's highest practicable physical, mental, and psychosocial wellbeing as required under 483.24, 483.25 or 483.40. The care plan must be developed within 7 days after completion of the comprehensive assessment. The care plan must be reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The care plan must address accurate needs regarding activities of daily living including locomotion and transfer abilities. This	

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 04/25/2018

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 657	Continued From page 6 the care plans usually when it was time for the care plan to be reviewed. She added that the goals would also be changed on the care plan if needed. The MDS nurse was interviewed on 4/25/18 at 1:27 PM. She stated the resident's care plan was last updated on 4/15/18 and stated that she needed 1-2 person assistance with transfers but that the resident did not need assistance anymore. She stated the resident was independent with ambulation and had met her therapy goals. She stated that for residents like this (short term residents), they would have an initial care plan. Then they would have a care plan meeting a few weeks later and would updated the care plan after talking to therapy (physical therapy). She stated that the nursing assistants have access to the entire care plan on the computer so they know how to transfer and care for the residents. The Director of Nursing stated on 4/25/18 at 2:03 PM that the care plan was usually updated every 30 days and the care plan was based on her admission assessment. If a resident had a change in status then they would update the care plan as they go along.	F 657	education will also be included in the orientation of any new MDS Nurses. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Director of Nursing and/or Administrator will conduct a review using the Care Plan Audit Tool: Activities of Daily Living to ensure the care plans are up to date and addressing any changes in the resident's locomotion and transfer abilities. The review will include auditing 5 resident care plans a week for 4 weeks and then 5 resident care plans a month for 2 months. Identified issues will be addressed with appropriate action. Reports will be presented to the QA committee by the Administrator and/or Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Therapy, Health Information Manager (HIM), and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Director of Nursing and/or Administrator Date of Compliance: May 22nd, 2018	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		5/22/18

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 04/25/2018

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 812	Continued From page 7 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to discard a food item within the use by date and failed to ensure foods were labeled, dated and stored in sealed containers. This was evident in 1 of 2 kitchen observations. Findings Included: An observation of the kitchen on 4/23/18 at 10:30 am with the Dietary Manager (DM) revealed the following: a. The walk-in refrigerator had an open container of macaroni salad with a label dated 4/13/18. b. The walk-in refrigerator contained a case of thawed mighty shakes that were not labeled with a use by date. c. The walk-in freezer had a case of chicken kiev, a case of french fries and a case of beef steak	F 812	F812- Food Procurement, Store/Prepare/Serve-Sanitary The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; The facility failed to discard a food item	

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 04/25/2018

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 812	Continued From page 8 burgers that were open, unsealed and exposed to the air. d. The reach-in refrigerator had a plastic bag of individual size pizzas that was open, unsealed and exposed to the air. An interview with the DM on 4/23/18 at 10:50 am revealed the macaroni salad should have been discarded within 7 days of opening. He stated the mighty shakes should be dated when they are thawed and used within 10 days of thawing. The DM added all food products should be sealed properly after being opened. An interview with the Administrator on 4/25/18 at 2:06 pm revealed it was his expectation that all foods were stored, labeled and dated according to regulations.	F 812	within the use by date and failed to ensure foods were labeled, dated, and stored in sealed containers. A. The open container in the walk-in refrigerator with a label dated 4/13/18 was discarded on 4/23/18 by the Dietary Manager. B. The case of thawed mighty shakes in the walk-in refrigerator that were not labeled were opened and dated on 4/23/18 by the Dietary Manager. C. The case of chicken kiev, case of French fries, and the case of beef steak burgers that were open, unsealed and exposed to air were discarded on 4/23/18 by the Dietary Manager. D. The plastic bag of individual size pizzas that were open, unsealed and exposed to air in the reach-in refrigerator were discarded on 4/23/18 by the Dietary Manager. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; The Administrator and Dietary Manager audited the entire kitchen and food storage location to ensure all food items were stored in the appropriate sealed containers, labeled and dated. This audit was completed on 4/27/18. The Dietary Manager and Administrator re-educated all Dietary staff on the requirements for labeling, dating, and storing food in appropriate sealed container. This education was completed by 4/27/18. All Dietary staff will be required to complete education prior to working after 4/27/18. This education will also be included in the orientation of any	

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 04/25/2018

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 812	Continued From page 9	F 812	new Dietary employees. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; The Administrator will conduct a kitchen tour with the Dietary Manager using the Food Storage Audit Tool. The audit will include weekly kitchen tours to include all food storage locations for 4 weeks and monthly for 2 months. Identified issues will be addressed with appropriate action. Reports will be presented to the QA committee by the Administrator to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Director of Nursing, MDS Coordinator, Unit Manager, Therapy, Health Information Manager (HIM), Dietary Manager, and the Administrator. The title of the person responsible for implementing the acceptable plan of correction; Administrator Date of Compliance: May 22nd, 2018	