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 12/15/2022

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

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E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted on 12/12/22 through 12/15/22. The facility was found in compliance with the requirement CFR 483.72, Emergency Preparedness. Event ID # 1MKY11.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey were conducted from 12/12/22 through 12/15/22. Event ID# 1MKY11. The following intake was investigated NC00191849. 2 of the 2 complaint allegations were not substantiated.	F 000		
F 638 SS=E	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments no later than 14 days after the Assessment Reference Date (ARD, the last day of the look-back period) for 4 residents (Residents #8, #7, #14, and #16) reviewed for resident assessments. The findings included: 1. Resident #8 was admitted to the facility on 4/7/21.	F 638	F638- Qrtly Assessment at Least Every 3 Months 483.20- Quarterly Review Assessment The plan of correction is prepared and submitted solely because of requirements of state and federal law. 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 incompliance with all Federal	1/20/23

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

Electronically Signed | 01/06/2023

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F 638	Continued From page 1 Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 11/21/22. As of 12/15/22, 24 days after the ARD, the quarterly MDS dated had not been completed. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator and she indicated she was behind in completing some assessments, which caused the assessment to be overdue. She indicated she was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fell behind in completing the assessments. She indicated the assessments should be completed in 14 days from the ARD. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 2. Resident #7 was admitted to the facility on 6/15/22. Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last	F 638	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. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility failed to complete quarterly Minimum Data Set (MDS) assessments no later than 14 days after the Assessment Reference Date (ARD, the last day of the look-back period) for 4 residents (Residents #8, #7, #14, and #16) reviewed for resident assessments. After a review of the deficient practice, 5 of 8 residents (Resident #8, #7, #14, #16) were found to have been affected, however, no residents were at harm from deficient practice. To identify any other residents having the potential to be affected by the same deficient practice, an audit was performed on 1/20/2023. The audit reviewed residents from November 1st,2022 to December 31st, 2022 in which 11 out of 23 residents were found to be	

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F 638	Continued From page 2 day of the look-back period) of 11/21/22. As of 12/15/22, 24 days after the ARD, the quarterly MDS dated had not been completed. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator and she indicated she was behind in completing some assessments, which caused the assessment to be overdue. She indicated she was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fell behind in completing the assessments. She indicated the assessments should be completed in 14 days from the ARD. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 3. Resident # 14 was admitted to the facility on 3/25/15. Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 11/22/22. The quarterly MDS dated 11/22/22 was signed/dated on 12/14/22 by the Assessment Coordinator to verify the assessment was completed (22 days after the ARD).	F 638	affected by the same deficient practice. However no residents were at harm of the deficient practice. As of 1/20/2023 all quarterly MDS assessments found to be affected from deficient practice from November 1st, 2022 through December 31st, 2022 audit are completed and up to date. As of 1/2/2023, facility has implemented an audit tool to ensure no other residents are affected by the deficient practice going forward. After review of the deficient practice, education was conducted by Administrator/Designee on 1/2/2023 with the Administrator, Director of Nursing, and MDS Coordinator to review MDS assessments to be completed no later than 14 days after the ARD. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 1/2/2023, education was conducted by Administrator/Designee with the Administrator, Director of Nursing and MDS Coordinator to review MDS assessments to be completed no later than 14 days after the ARD. Administrator, Director of Nursing and MDS Coordinator will meet weekly to review assessments and ARD to ensure completion no later than 14 days after the ARD. An audit will be conducted utilizing a calendar tool to ensure completion of MDS assessments that are due no later than 14 days after	

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F 638	Continued From page 3 An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator and she indicated she was behind in completing some assessments, which caused the assessment to be overdue. She indicated she was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fell behind in completing the assessments. She indicated the assessments should be completed in 14 days from the ARD. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 4. Resident #16 was admitted to the facility on 4/27/21. Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 11/5/22. The quarterly MDS dated 11/5/22 was signed/dated on 11/21/22 by the Assessment Coordinator to verify the assessment was completed (16 days after the ARD). An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator and she	F 638	ARD. On 1/3/2023, Administrator reviewed with QA team of weekly meetings to ensure completion of MDS assessments are completed no later than 14 days after the ARD. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 1/3/2023, Administrator reviewed with QA team of weekly meetings to ensure completion of MDS assessments are completed no later than 14 days after the ARD. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental manager.	

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F 638	Continued From page 4 indicated she was behind in completing some assessments, which caused the assessment to be overdue. She indicated she was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fell behind in completing the assessments. She indicated the assessments should be completed in 14 days from the ARD. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely.	F 638	Weekly meetings between the Administrator, Director of Nursing and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Reports/Audits will be presented to the QA committee monthly by MDS Coordinator or Director of Nursing/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 640		1/20/23

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F 640	Continued From page 5 §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete Minimum Data Set (MDS) discharge assessments for 5 of 8 discharged residents reviewed (Residents #29,	F 640	F640- Encoding/Transmitting Resident Assessments 483.20- Automated Data Processing	

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F 640	Continued From page 6 #62, #24, #47, #37). Findings included: 1. Resident #29 was admitted to the facility on 6/17/22. Nursing documentation dated 7/2/22 noted the resident had discharged from the facility to the community. There was no discharge MDS completed for Resident #29. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator. She indicated she was behind in completing some assessments, had not completed the discharge assessments, and was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fallen behind. She indicated the assessments should be completed within 14 days from the discharge date. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 2. Resident #62 was admitted to the facility on 6/23/22.	F 640	Requirement The plan of correction is prepared and submitted solely because of requirements of state and federal law. 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 incompliance 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. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility failed to complete Minimum Data Set (MDS) discharge assessments for 5 of 8 discharged residents reviewed (Residents #29, #62, #24, #47, #37). After a review of the deficient practice, 5 of 8 residents (Resident #29, #62, #24, #47, #37) were found to have been affected, however no residents were at harm of deficient practice. To identify any	

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F 640	Continued From page 7 Nursing documentation dated 7/8/22 noted the resident had discharged from the facility to the community. There was no discharge MDS completed for Resident #62. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator. She indicated she was behind in completing some assessments, had not completed the discharge assessments, and was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fallen behind. She indicated the assessments should be completed within 14 days from the discharge date. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 3. Resident #24 was admitted to the facility on 7/6/22. Nursing documentation dated 7/29/22 noted the resident had discharged from the facility to an assisted living facility. There was no discharge MDS completed for Resident #24. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator. She	F 640	other residents having the potential to be affected by the same deficient practice, an audit was performed 1/20/2023. The audit reviewed residents from December 1st through December 31st, 2022 in which showed 4 of 10 residents were affected by the same deficient practice, however no residents were at harm of the deficient practice. As of 1/20/2023 all discharge assessments from the December 1st, 2022 through December 31st, 2022 audit are completed and up to date. As of 1/2/2023, facility implemented an audit tool to ensure no other residents are affected by the deficient practice going forward. After review of the deficient practice, education was conducted by Administrator/Designee on 1/2/2023 with the Administrator, Director of Nursing, and MDS Coordinator to review MDS discharge assessments and the completion of discharge assessments no later than 14 days from the discharge date. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 1/2/2023, education was conducted by Administrator/Designee with the Administrator, Director of Nursing, and MDS Coordinator to review MDS discharge assessments to be completed no later than 14 days after resident	

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F 640	Continued From page 8 indicated she was behind in completing some assessments, had not completed the discharge assessments, and was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fallen behind. She indicated the assessments should be completed within 14 days from the discharge date. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 4. Resident #47 was admitted to the facility on 7/20/22. Nursing documentation dated 8/3/22 noted the resident had discharged to from the facility to the community. There was no discharge MDS for Resident #47. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator. She indicated she was behind in completing some assessments, had not completed the discharge assessments, and was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fallen behind. She indicated the assessments should be completed	F 640	discharges. Administrator, Director of Nursing and MDS Coordinator will meet weekly to review discharge assessments and to ensure completion no later than 14 days after the resident discharges. An audit will be conducted utilizing a calendar tool to ensure completion of MDS discharge assessments that are due no later than 14 days after resident discharges. On 1/3/2023, Administrator reviewed with QA team of weekly meetings to ensure completion of MDS discharge assessments are completed no later than 14 days after the discharge date. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 1/3/2023, Administrator reviewed with QA team of weekly meetings to ensure	

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F 640	Continued From page 9 within 14 days from the discharge date. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed. She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely. 5. Resident #37 was admitted to the facility on 7/25/22. Nursing documentation dated 8/25/22 noted the resident had discharged from the facility to an assisted living facility. There was no discharge MDS completed for Resident #37. An interview was conducted on 12/15/22 at 12:25 PM with the facility's MDS Coordinator. She indicated she was behind in completing some assessments, had not completed the discharge assessments, and was working to get them completed. She indicated she had been pulled from the MDS department to work on the medication cart and had fallen behind. She indicated the assessments should be completed within 14 days from the discharge date. An interview was conducted on 12/15/22 at 4:30 PM with the facility's Administrator. During the interview, the Administrator indicated she was aware of concerns regarding the MDS assessments being overdue and not completed.	F 640	completion of MDS discharge assessments are completed no later than 14 days after resident discharges. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Reports/Audits will be presented to the QA committee monthly by MDS Coordinator or Director of Nursing/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.	

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F 640	Continued From page 10 She indicated resident care was their priority and had to assign the MDS coordinator to the medication cart at times. She indicated the MDS coordinator was working to get the assessments completed and caught up. The Administrator indicated it was her expectation that the MDS assessments are completed timely.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and 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)-	F 656		1/6/23

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	345390	A. BUILDING _____ B. WING _____	C 12/15/2022

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F 656	Continued From page 11 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident #219) reviewed for pressure ulcers. The findings included: Resident #219 was admitted to the facility on 11/5/21 with a diagnosis that included joint replacement surgery, paraplegia, and unspecified fracture of shaft of left tibia. Resident was discharged to home from the facility on 2/26/22. A review of the comprehensive minimum data set (MDS) dated 11/12/21 revealed Resident #219 was cognitively intact and at risk for developing pressure ulcers. The care area assessment (CAA) dated 11/16/21 indicated to proceed to care plan for the prevention of developing pressure ulcers.	F 656	F656- Develop/Implement Comprehensive Care Plan 483.21- Comprehensive Care Plan The plan of correction is prepared and submitted solely because of requirements of state and federal law. 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 incompliance 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	

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F 656	Continued From page 12 A review of the care plan dated 11/16/21 revealed that Resident #219 was not care planned for being at risk to develop pressure ulcers. An interview with the MDS coordinator on 12/15/22 at 3:00 pm. She indicated that Resident #219 was coded correctly to be at risk for pressure ulcers and this should have been care planned and that it must have missed and not carried over as planned. A review of nursing progress note dated 11/17/21 indicated that Resident #219 developed a stage 2 pressure ulcer. An interview with the Administrator on 12/15/22 at 3:45 pm revealed that it was her expectation for the MDS nurse to have care planned this resident for being at risk for pressure ulcers.	F 656	address the processes that lead to the deficiency cited. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident #219) reviewed for pressure ulcers. After a review of the deficient practice, no residents (Resident #219) were found to have been affected. After a thorough review, an audit was performed to other residents with a comprehensive MDS stating if resident is at risk for pressure ulcers to ensure it is appropriately care planned. To identify any other residents having the potential to be affected by the same deficient practice, no other residents were seen to be affected at this time. After review of the deficient practice, education was conducted by Administrator/Designee on 1/2/2023 with the Administrator, Director of Nursing, and MDS Coordinator, to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a residents	

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F 656	Continued From page 13	F 656	medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 1/2/2022, education was conducted by Administrator/Designee with the Administrator, Director of Nursing, MDS Coordinator, to develop and implement a comprehensive person- centered care plan for each resident, consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Administrator, Director of Nursing and MDS Coordinator will meet weekly to review and audit comprehensive care plans. An audit will be conducted to ensure completion of comprehensive person-centered care plan for each resident is consistent with the resident rights set forth and that includes measurable objectives and timeframes to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. On 1/3/2023, Administrator/Director of Nursing reviewed with QA team of weekly	

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F 656	Continued From page 14	F 656	meetings to ensure accuracy and completion of resident's comprehensive care plans. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for the next 3 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 1/3/2023, Administrator/Director of Nursing reviewed with QA team of weekly meetings to ensure accuracy and completion of resident's comprehensive care plans. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Weekly meetings between the Administrator, Director of Nursing, and MDS Coordinator will be held for the next 4 weeks and thereafter once a month for	

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F 656	Continued From page 15	F 656	the next 3 months. Reports/Audits will be presented to the QA committee monthly by MDS Coordinator or Director of Nursing/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a Registered Nurse (RN) scheduled for 8 consecutive hours a day for 1 (11/24/22) of 30 days reviewed.	F 727	F727- RN 8 Hrs/7 days/Wk, Full Time DON 483.35: Registered Nurse	1/6/23

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F 727	Continued From page 16 Findings included: The daily nursing schedules from 11/12/22 through 12/12/22 were reviewed and revealed there was no registered nurse (RN) on 11/24/22. Review of the timecards and RN scheduled staffing assignment sheets revealed the facility had no documentation of an RN present in the facility on 11/24/22 to meet the requirement for an RN at least 8 consecutive hours per day on each day. During an interview conducted with the Administrator on 12/15/22 at 9:30 am she stated there should have been an RN scheduled every day. However, on Thanksgiving Day (11/24/22) no RN was present in the facility An interview was conducted with Nurse #2 on 12/15/22 at 1:19 pm she indicated she was a RN and that she believed she worked on 11/24/22. Review of Nurse #2's timecard for 11/24/22 indicated she did not work. An interview was conducted with the Director of Nursing on 12/15/22 at 3:10 pm. She stated she expected the facility to have an RN staffed to meet the regulation for 8 consecutive hours a day, 7 days a week. During an interview conducted with the Administrator on 11/15/22 at 3:30pm she stated she expected the Scheduler to staff an RN for 8 hours per day, 7 days a week.	F 727	The plan of correction is prepared and submitted solely because of requirements of state and federal law. 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 incompliance 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. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The facility failed to have a Registered Nurse (RN) scheduled for 8 consecutive hours a day for 1 (11/24/22) of 30 days reviewed. After a review of the deficient practice, no residents were found to have been affected. To identify any other residents having the potential to be affected by the same deficient practice, no other residents were seen to be affected at this time.	

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F 727	Continued From page 17	F 727	After review of the deficient practice, education was completed on 12/16/2022 with the Administrator, Director of Nursing, and Scheduler, to ensure facility has 8 consecutive hours of RN coverage seven days a week. Address what measures will be put into place or systemic changes made to ensure what the deficient practice; On 12/16/2022, education was conducted by Administrator/Designee with the Administrator, Director of Nursing, scheduler to ensure facility has 8 consecutive hours of RN coverage seven days a week. A daily audit has been implemented to ensure 8 consecutive hours of RN coverage for seven days a week. The audit will be completed by the scheduler and Director of Nursing/Designee to ensure a double check. On 12/20/2022, Administrator/Director of Nursing reviewed with QA team of daily audits to ensure 8 consecutive hours of RN coverage for seven days a week. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.	

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F 727	Continued From page 18	F 727	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. On 12/20/2022, Administrator/Director of Nursing reviewed with QA team of a daily audit to ensure facility has 8 consecutive hours of RN coverage seven days a week. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers. Daily meetings between the Scheduler and Director of Nursing/Designee will be held for the next 4 weeks and thereafter once a month for the next 3 months. Reports/Audits will be presented to the QA committee monthly by the Director of Nursing/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA committee consists of Medical Director (only quarterly), DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) and other departmental managers.	