

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments An unannounced recertification survey was conducted from 09/14/2021 through 09/17/2021. The facility was found in compliance with the requirement 42 CFR §483.73 related to E-0024 (b)(6), Emergency Preparedness. Event ID # QU7T11.	E 000			
F 000	INITIAL COMMENTS An onsite recertification survey, complaint investigation and focused infection control survey were completed on 09/14/21 through 09/17/21. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 7 of 7 complaint allegations were not substantiated. Event ID # QU7T11.	F 000			
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		9/22/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/04/2021

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.

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 578	<p>Continued From page 1</p> <p>residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff and resident interviews, and record review, the facility failed to maintain accurate advance directive information throughout the medical record for 1 of 6 residents reviewed for formulation of advance directives (Resident #45).</p> <p>The findings included:</p> <p>Resident #45 was admitted to the facility on 02/12/21. He had diagnoses that included adult failure to thrive and malnutrition.</p> <p>Resident #45's admission Minimum Data Set</p>	F 578	<p>F578- Request/Refuse/Discontinue Treatment; Formulate Advance Directive</p> <p>The directed 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 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</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 578	<p>Continued From page 2</p> <p>dated 02/19/21 revealed he had intact cognition.</p> <p>The hospital records dated 02/12/21 revealed Resident #45 was determined to be a Do Not Resuscitate (DNR) and indicated for no cardiopulmonary resuscitation (CPR). The hospital Medical Provider documented a DNR status for Resident #45 on the discharge instructions. A completed and signed DNR dated 02/12/21 accompanied Resident #45 to the facility.</p> <p>Resident #45's electronic medical record (EMR) revealed a signed physician order for full code status dated 02/12/21 with no expiration date. The face sheet revealed a signed DNR form under the advance directive tab dated 02/12/21 with the no expiration date box checked on the document.</p> <p>An interview was conducted with Nurse Aide #1 on 09/15/21 at 01:08 PM. She revealed she reviewed a resident's code status in the EMR and she used the EMR as a source of information for a resident's code status.</p> <p>In an Interview with Nurse #1 on 09/15/21 at 01:10 PM, she explained there were multiple places in the EMR to view code status information. Nurse # 1 stated, "it never hurts" to check all areas of code status documentation.</p> <p>An interview with Medical Records on 09/15/21 at 01:38 PM revealed she scanned DNRs into the EMR after she received the document in her items-to-be scanned box. She explained DNR forms mostly come from the hospital. She stated all DNRs should be scanned into the EMR.</p>	F 578	<p>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.</p> <p>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.</p> <p>The facility failed to maintain accurate advance directive information throughout the medical record for 1 of 6 records reviewed for formulation of advance directives.</p> <p>Effective 9/21/2021, code status will be checked by Admission Director and Medical Records and/or designee for all new admission and/or any changes to code statuses. Administrator/designee immediately removed the DNR form from Resident #45's EHR. Resident #45 was found to be unaffected due to patient and family confirming code status as a full code. Immediately the DNR medical record was taken off resident EMR medical records.</p> <p>To identify residents having the potential to be affected by same deficient practice, the facility's Medical Records Coordinator</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 578	<p>Continued From page 3</p> <p>An Interview with the Social Worker was conducted on 09/15/21 at 3:40 PM. The Social Worker indicated she did not speak with Resident #45 or his family regarding his code status.</p> <p>In a follow up interview and observation with Nurse # 1 at 09/15/21 at 03:57 PM she reviewed Resident #45's EMR. Nurse #1 stated he was a full code. When she reviewed the DNR form under the advance directives tab, Nurse #1 stated she did not know he had a scanned DNR.</p> <p>An interview was conducted with Resident #45 on 09/16/21 at 08:54 AM. Resident #45 revealed the facility had not spoken with him regarding his wishes for full code or DNR status.</p> <p>In a follow up interview with Medical Records on 09/16/21 at 12:06 PM, she indicated a DNR form remained scanned in the EMR once the DNR was rescinded.</p> <p>An interview with the Admission Coordinator on 09/16/21 at 12:01 PM explained the process for formulating advance directives. She communicated if a resident was admitted to the facility from a hospital with a DNR, she asked the resident or resident representative for verification of the current code status. If the DNR was accurate, it was scanned into the EMR.</p> <p>A follow up interview with the Admission Coordinator was completed on 09/16/21 at 12:14 PM. The Admission Coordinator voiced she had spoken with Resident #45's family upon admission regarding Resident #45's code status. The family determined Resident #45 was a full code.</p>	F 578	<p>on 9/21/21 conducted an audit of all residents with advance directives or DNR orders to ensure that they accurately reflected the resident's status and choices. This audit was completed as of 9/21/21. As a result of this audit, no other residents were found to be affected at the time.</p> <p>Address what measures will be put into place or systemic changes made to ensure what the deficient practice;</p> <p>Education was developed and implemented on the process of Advance Directives at Admission and/or any changes in code statuses, which included a description of the facility's advance directives intake process and related medical record documentation at admission.</p> <p>That Advance Directives process is as follows:</p> <ol style="list-style-type: none"> 1. At admission review Advance Directives with patient and or legally-authorized representative of resident to confirm whether the resident has any advance directives (living will, health care power of attorney, durable power of attorney) or has a standing/portable DNR Order (such as the yellow goldenrod DNR or a Medical Order for Scope of Treatment Order). 2. If so, request a copy of the resident's advance directive or ensure any portable DNR order the resident indicates they have is part of the medical record. 3. Ensure that any portable DNR orders 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 578	<p>Continued From page 4</p> <p>An interview was conducted with Resident #45's family member on 09/16/21 at 01:26 PM. The family member indicated she believed she had spoken with staff during the admission process and thought she and her brother had made Resident #45 a full code status. The family member stated she needed to clarify this statement with her brother.</p> <p>In a follow up interview with Resident #45 on 09/16/21 at 4:03 PM, the resident indicated he would want to be resuscitated.</p> <p>In an interview with the Director of Nursing (DON) on 09/16/21 at 04:12 PM, she revealed the admission coordinator speaks with the family or resident upon admission to review code status information. She further indicated the care plan team discussed code status changes as needed. The DON explained all resident information had to be scanned into the EMR. She further explained staff go by the physician's order for code status and not scanned documents.</p> <p>An interview was conducted with the DON and Administrator on 09/16/21 at 05:11 PM. The DON reviewed Resident #45's EMR and confirmed the full code order and scanned DNR order were both dated for 02/12/21 and both signed by a provider with no expiration dates indicated. The DON stated the scanned DNR was part of the EMR and cannot be changed. She further explained code statuses could change at the time of admission. The Administrator explained everything gets scanned into the EMR that comes to the facility with the resident. When a code status changes, the doctor's order would be updated.</p>	F 578	<p>in the resident's medical record accurately reflects the resident's DNR choice by discussing same with resident and/or legal representative of resident</p> <p>4. Ensure the resident's medical record contains a current, valid doctor's order which accurately reflects the resident's full code or DNR status choices, as expressed by the resident or their legal representative</p> <p>5. In the event the resident's medical record contains a portable DNR Order which does not conform to the resident's stated code wishes, immediately notify the resident's attending physician for resolution of this conflict</p> <p>6. Nurse and/or designee provide resident's DNR order or advance directive to medical records to review, double check and upload to EHR</p> <p>7. DNR form goes into patient chart at nurses' station</p> <p>This education was provided to all administrative, Charge Nurses, Nursing Supervisors, Admission Director, and Social Worker and was completed as of 9/22/21. Any staff who were not available for this training will not be allowed to return to work until the training is completed.</p> <p>On 9/21/2021, Administrator presented Advance Directive Process to QA team to review and implement. The accurate implementation of this Advance Directives process will be reviewed on a monthly basis by the QA Committee as a facility review to ensure</p>		

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 578	Continued From page 5	F 578	<p>accuracy of all code statuses.</p> <p>The QA committee consists of Medical Director, DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resource, Social Work, Plant Operations Manager, etc.</p> <p>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.</p> <p>The Admission Director/ Social Worker/ Medical Records/Designee will perform an audit of the DNR and advance directives status of all new admissions and/or residents who express a desire for changes in code status. These audits will be conducted weekly for 4 weeks, then monthly for the next three months. Reports of the audits will be presented to the QA committee monthly by Medical Records Coordinator/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Medical Director (only quarterly), Director of Nursing, MDS Coordinator, Nursing Supervisors, Therapy, Administrator and other departmental managers.</p>		
F 732 SS=C	<p>Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4)</p> <p>§483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.</p>	F 732		9/22/21	

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	<p>Continued From page 6</p> <p>(ii) The current date.</p> <p>(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p> <p>(A) Registered nurses.</p> <p>(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).</p> <p>(C) Certified nurse aides.</p> <p>(iv) Resident census.</p> <p>§483.35(g)(2) Posting requirements.</p> <p>(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.</p> <p>(ii) Data must be posted as follows:</p> <p>(A) Clear and readable format.</p> <p>(B) In a prominent place readily accessible to residents and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, staff interviews and record review, the facility failed to ensure daily nurse staffing information was completed for 30 of 30 days reviewed for completed staffing information.</p>	F 732	<p>F732- Posted Nurse Staffing Information 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</p>		

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	<p>Continued From page 7</p> <p>Findings Included:</p> <p>A review of facility staffing information dated 08/17/21 through 09/15/21 (30 days), revealed the resident census number was not entered for 2nd and 3rd shifts on all days.</p> <p>An interview was conducted on 09/17/21 at 03:18 PM with the scheduler who was responsible for posting daily staffing. She explained that she and the Director of Nursing (DON) share the responsibility for completing the staff census information.</p> <p>An interview was conducted with the DON on 09/17/at 03:47 PM. The DON explained the process for making changes or updates to the staffing information. During workdays, it was the responsibility of the scheduler or DON to update the staffing information. The DON revealed afterhours it was the responsibility of whoever was at the facility that took the call out from staff members (usually a nurse). The DON revealed the resident census number was updated when the information changed. She stated if the resident census number didn't change, it was not rewritten each shift.</p>	F 732	<p>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.</p> <p>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.</p> <p>The facility failed to ensure daily nurse staffing information was completed for 30 of 30 days reviewed for completed staffing information due to resident census number was not entered for 2nd and 3rd shifts on all days.</p> <p>After a thorough review, no residents were found at the time to be affected by the deficient practice.</p> <p>To identify residents having the potential to be affected by same deficient practice, an audit was put into place to ensure census staffing sheet is completed with accuracy. Director of Nursing immediately completed 9/20/21 an initial review and correction on the staffing census sheet from 8/16/21-9/17/21.</p>		

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	Continued From page 8	F 732	<p>An audit form is implemented to ensure a double check with two signatures by the DON/Designees to ensure the accuracy of census staffing sheet is posted with completed staffing information it's in entirety.</p> <p>DON/Scheduler/Night Nurse/Designee is responsible to keep the census staffing sheet posted with sheet completed in its entirety.</p> <p>Address what measures will be put into place or systemic changes made to ensure what the deficient practice;</p> <p>On 9/20, the Director of Nursing (DON) and Administrator reviewed the process of the accuracy of the census staffing sheet. Education was performed 9/21/21 with administrative team on census staffing sheet. Education was performed 9/22/21 for all nurses regarding census staffing sheet. The process was implemented with a double check to ensure the accuracy and posting of the census staffing sheet.</p> <p>The census staffing sheets audits will be implemented immediately 9/20/21 to ensure the census staffing sheet are posted with the accuracy in its entirety. The audit form will include a double check by the Director of Nursing/scheduler/designee to ensure the accuracy of the staffing census sheet. The Staffing Census sheet and audit form was reviewed by Director of Nursing (DON) and Administrator and was implemented 9/20/21.</p>		

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

PRINTED: 10/20/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2021
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 732	Continued From page 9	F 732	<p>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.</p> <p>The Director of Nursing and Designee will review census staffing sheet daily for the next 4 weeks to ensure census staffing sheets are completed accurately. Thereafter, Director of Nursing/ Designee will review census staffing sheets once a month for the next three months to ensure census staffing sheets are completed accurately daily.</p> <p>Reports/Audits will be presented to the QA committee by Director of Nursing/Administrator/Designee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The QA Meeting is attended by the Medical Director, Director of Nursing, MDS Coordinator, Nursing Supervisors, Therapy, Administrator and other departmental managers.</p>		