PRINTED: 06/12/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345390 B. WING				C 05/02/2025			
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE				STREET ADDRESS, CITY, STATE, ZIP 7700 US HIGHWAY 158 STOKESDALE, NC 27357	CODE	, <u></u>	02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
E 000	Initial Comments		E	000				
F 000	investigation survey was through 5/2/25. The compliance with the r	equirement CFR 483.73, Iness. Event ID # V9T511.	F (000				
	An unannounced recertification and complaint investigation survey was conducted on 4/29/25 through 5/2/25. Event ID# V9T511. The following intakes were investigated NC00227147 and NC00228039.							
F 641 SS=D	7 of 7 allegations did Accuracy of Assessm CFR(s): 483.20(g)(h)		F 6	641			5/8/25	
	§483.20(g) Accuracy The assessment mus resident's status.	of Assessments. It accurately reflect the						
	conduct or coordinate	ion. A registered nurse must e each assessment with the ion of health professionals.						
	certify that the assess §483.20(i)(2) Each in portion of the assessi	ered nurse must sign and						
	individual who willfully (i) Certifies a material	Medicare and Medicaid, an						
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				TITI F			(X6) DATE	

Electronically Signed 05/23/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 641			F 64	Address how corrective action accomplished for those reside have been affected by the defipractice; Address how the faci identify other residents having potential to be affected by the deficient practice. The facility failed to accurately Minimum Date Set (MDS) ass the areas of respiratory care a diagnosis for 2 of 14 residents	ents found to icient ility will the same / code the essment in and active s reviewed	
	physician order day canula at 2 liters por level of greater that A record review of Medication Administrate and the control of the quarterly Minimassessment dated Resident #32 had a not interview was control of the c	ted 9/1/24 for oxygen via nasal er minute to maintain oxygen in 92%. Resident #32's February 2025 stration Record (MAR) herapy was administered daily. mum Data Set (MDS) 2/24/25 did not indicate received oxygen therapy. onducted on 5/1/25 at 3:39 PM a Set (MDS) Nurse #1. She ersight that MDS Nurse #2 did		#41). The MDS assessment we corrected on resident #32 and 5/2/2025. After a thorough review, an aux performed to all other resident review of the deficient practice residents were found to have a laffected in the areas of respiral and active diagnosis. To identification residents having the potential affected by the same deficient of 51 residents were corrected 5/2/2025.	vas #41 on dit was ts. After a e, 9 of 51 been atory care ify any other to be practice, 9 d on	
	This REQUIREME by: Based on record rescility failed to accompate Set (MDS) as respiratory care and residents reviewed #32 and #41). The findings included 1. Resident #32 was 5/17/24 with diagnoral Arecord review incomphysician order day canula at 2 liters polevel of greater that A record review of Medication Administrevealed oxygen that The quarterly Minimassessment dated Resident #32 had an interview was considered it was an overside to accomplish the policy of the policy	eview and staff interviews, the curately code the Minimum issessment in the areas of d active diagnosis for 2 of 14 for MDS accuracy (Residents ed: as admitted to the facility on isses that included pneumonia. dicated Resident #32 had a sted 9/1/24 for oxygen via nasaler minute to maintain oxygen in 92%. Resident #32's February 2025 stration Record (MAR) is reapy was administered daily. mum Data Set (MDS) 2/24/25 did not indicate received oxygen therapy. onducted on 5/1/25 at 3:39 PM is Set (MDS) Nurse #1. She		accomplished for those reshave been affected by the practice; Address how the identify other residents have potential to be affected by deficient practice. The facility failed to accurate Minimum Date Set (MDS) the areas of respiratory cardiagnosis for 2 of 14 reside for MDS accuracy (Reside #41). The MDS assessment corrected on resident #32 5/2/2025. After a thorough review, an performed to all other residents were found to have affected in the areas of residents having the potent affected by the same deficient of 51 residents were corrected.	side defi faci ving the ately assure a ents # nt w and n au dent ctice ave I spiral denti ctector ctector ave I ctector ately	sidents found to deficient facility will ving the the same ately code the assessment in re and active ents reviewed ent #32 and nt was and #41 on In audit was dents. After a ctice, 9 of 51 ave been spiratory care dentify any other stial to be cient practice, 9 cted on

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					700 US HIGHWAY 158		
COUNTRY	'SIDE				TOKESDALE, NC 27357		
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F 641	Continued From page	÷ 2	F	641			
	#32's quarterly MDS an interview was con	rams section of Resident assessment dated 2/24/25. ducted on 5/1/25 at 3:56 PM			education was conducted by VP of MD Services/Designee on 5/5/2025 with M Coordinator to review accuracy of MDS the areas of respiratory care and active diagraphs.	DS S in	
	with the Director of Nursing. She stated she expected the MDS assessments to be coded accurately. 2. Resident #41 was admitted to the facility on 6/22/23 with a diagnosis that included anxiety disorder. A record review indicated Resident #41 had an				diagnosis. Address what measures will be put into place or systemic changes made to)	
					ensure what the deficient practice; On 5/5/2025, education was conducted	1 hv	
					VP of MDS Services/Designee with the MDS Coordinator to review accuracy of	•	
	active diagnosis of bi	polar disorder since 7/3/23.			MDS in the areas of respiratory care at active diagnosis. Administrator, Director	nd or of	
	from 3/18/25-3/24/25	ation Administration Record revealed Resident #41 c medication daily for bipolar			Nursing and MDS Coordinator will mee weekly to review assessments and AR to ensure accuracy of MDS in the area	D	
	disorder.	· · · · · · · · · · · · · · · · · · ·			respiratory care and active diagnosis.		
	The quarterly Minimu assessment dated 3/2	, ,			On 5/8/2025, Administrator reviewed w QA team of weekly meetings to ensure		
	Resident #41 had an active diagnosis of bipolar disorder in the Psychiatric/Mood Disorder section. An interview was conducted on 5/2/25 at 9:33 AM with Minimum Data Set (MDS) Nurse #1. She stated it was an oversight that the MDS Nurse #2 did not code an active diagnosis of bipolar disease in the Psychiatric/Mood Disorder section of Resident #41's quarterly MDS assessment				accuracy of MDS in the areas of respiratory care and active diagnosis. QA committee consists of Medical	The	
					Director (only quarterly), DON, Administrator, MDS Coordinator, Nursi Supervisor, Human Resource, Social	ng	
					Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly) a other departmental managers.	and	
	dated 3/24/25.	·			Weekly meetings between the Administrator, Director of Nursing and		
	AM with the Administ	ducted on 03/06/25 at 10:50 rator. He stated she sessments to be coded			MDS Coordinator will be held for the notation 4 weeks and thereafter once a month for the next 3 months.		
	accuratery.				Indicate how the facility plans to monitority its performance to make sure that	or	

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					52.18.2.16.7			
F 641	Continued From page	e 3	F 6	341				
					solutions are sustained; and Include da	ıtes		
					when corrective action will be complete	∌d.		
					On 5/8/2025, Administrator reviewed w			
					QA team of weekly meetings to ensure			
					accuracy of MDS in the areas of			
					respiratory care and active diagnosis.	he		
					QA committee consists of Medical			
					Director (only quarterly), DON, Administrator, MDS Coordinator, Nursi	na		
					Supervisor, Human Resource, Social	ıy		
					Worker, Plant Operations Manager,			
					Pharmacy Consultant (only quarterly) a	and		
					other departmental manager.			
					Weekly meetings between the			
					Administrator, Director of Nursing and			
					MDS Coordinator will be held for the ne	ext		
					4 weeks and thereafter once a month f	or		
					the next 3 months.			
					Reports/Audits will be presented to the			
					committee monthly by MDS Coordinate			
					or Director of Nursing/Designee to ens	ıre		
					corrective action for trends or ongoing	_		
					concerns is initiated as appropriate. Th	е		
					QA committee consists of Medical			
					Director (only quarterly), DON, Administrator, MDS Coordinator, Nursi	na		
					Supervisor, Human Resource, Social	ıy		
					Worker, Plant Operations Manager,			
					Pharmacy Consultant (only quarterly) a	and		
					other departmental managers.			
					,			
					Completion date 5/8/2025.			
F 656	Develop/Implement C	Comprehensive Care Plan	F 6	556	•		5/8/25	
SS=D								
	§483.21(b) Comprehe							
	§483.21(b)(1) The fac	cility must develop and						

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F 656	care plan for each re resident rights set for §483.10(c)(3), that is objectives and timef medical, nursing, an needs that are ident assessment. The codescribe the followin (i) The services that or maintain the reside physical, mental, an required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclutreatment under §48 (iii) Any specialized rehabilitative service provide as a result or recommendations. If findings of the PASA rationale in the reside (iv) In consultation we resident's representational (iv) In consultation we resident's profuture discharge. Fawhether the resident community was asset local contact agencicentities, for this purp (C) Discharge plans plan, as appropriate	chensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable rames to meet a resident's diffied in the comprehensive in more than and psychosocial ified in the comprehensive in more than are to be furnished to attain lent's highest practicable in the practicable in	F 656			

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F 656	by the facility, as ou care plan, must- (iii) Be culturally-cor This REQUIREMEN by: Based on record re facility failed to deverespiratory care for comprehensive care. The findings include Resident #32 was a 5/17/24 with diagnost A record review indiphysician order date canula at 2 liters pellevel of greater than The quarterly Minimassessment dated 2 Resident #32 had read to A record review of Findication Administrate and the Review of Resident Review of Resident	ervices provided or arranged tlined by the comprehensive inpetent and trauma-informed. T is not met as evidenced view and staff interviews, the elop a care plan in the area of 1 of 14 residents reviewed for e plans (Resident #32). d: d: dmitted to the facility on sis that included pneumonia. cated Resident #32 had a and 9/1/24 for oxygen via nasal reminute to maintain oxygen 92%.	F 6	,	re plan in of 14 ed for actice, no und to ation vealed d. On an was spiratory audit ents. To ag the me ats were		
	observed in room in concentrator in use,	AM, Resident #32 was bed with the oxygen but the oxygen tubing was who was observed to be		5/1/2025, all 6 care plans were u reflect respiratory care. After review of the deficient pract education was conducted by VP Services/Designee on 5/5/2025 v MDS Coordinator, to develop and implement a comprehensive pers	ice, of MDS vith the		

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F 656	Continued From page	≥ 6	F 6	56			
F 030	An interview was con 4/30/35 at 3:05 PM. N #32 was known to rer from her nose and for nursing staff had to m oxygen tubing as nee saturation remained at An interview was con on 5/1/25 at 3:39 PM Resident #32 should developed for respira oversight. An interview was con Nursing on 5/1/25 at 4 that Resident #32 should tha	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 6 Interview was conducted with Nurse #1 on 10/35 at 3:05 PM. Nurse #1 indicated Resident 12 was known to remove her oxygen tubing 15 m her nose and forget to replace it therefore 15 rsing staff had to monitor and reposition the 16 rygen tubing as needed to ensure her oxygen 17 ruration remained above 92%. Interview was conducted with MDS Nurse #1 15/1/25 at 3:39 PM and she indicated that 15 sident #32 should have had a care plan 17 yeloped for respiratory care and that it was an 17 in the 17 page 18 p		centered care plan for ear consistent with the reside and that includes measured and timeframes to meet a medical, and nursing need. Address what measures place or systemic change ensure what the deficient. On 5/5/2025, education of VP of MDS Services/Desides MDS Coordinator, to devimplement a comprehensic centered care plan for ear consistent with the reside and that includes measured and timeframes to meet a medical and nursing need. Administrator, Director of MDS Coordinator will measure completion of corperson-centered care plans. An audit will be consured completion of corperson-centered care plans are sident is consistent with rights set forth and that it measurable objectives and meet a residents medical needs. On 5/8/2025, Administration Nursing reviewed with Quincetings to ensure accurate plans. The QA committed in the provision of the plans of the plans of the plans. The QA committed in the plans of th	ent rights set for rable objective a resident eds. will be put into es made to transcribe either eds. will be put into es made to transcribe either	by Orth s to	

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F 656	Continued From page	. 8	F 65	Worker, Plant Operations Manager, Pharmacy Consultant (only quarterly other departmental managers. Completion date 5/8/2025.) and	