Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/28/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Care Center	925 North Cornelia Fresno, CA 93706

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on interview, and record review, the facility failed to ensure residents received adequate supervision to prevent accidents for one of three sampled residents (Resident 1) when Resident 1 was assessed to be at high risk for falls requiring one-on-one observation for safety and Certified Nursing Assistant (CNA) 2 left the resident unattended and out of sight while she assisted another resident. This failure resulted Resident 1 falling and sustaining lacerations (skin and underlying tissues are cut or torn) and contusions (bruise caused by a direct blow to the body) to his head requiring the resident's transfer to the emergency department (ED) for treatment. Findings: During an interview on 5/30/24 at 9:03 a.m. with the Administrator (ADM), the ADM stated Resident 1 fell in the early morning hours on 5/30/24. The ADM stated Resident 1 had a change in condition prior to the fall and a CNA was assigned to provide one-on-one supervision. The ADM stated the CNA had left Resident 1 briefly to help a CNA with another resident in the room and they heard a loud bang and found Resident 1 on the ground. The ADM stated Resident 1 was sent to the acute care hospital (ACH) ED. During a review of Resident 1's Admission Record (AR-a document containing resident demographic information and medical diagnosis), undated, the AR indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems), fracture (broken bone) of body of sternum (the long flat bone that forms the center front of the chest wall), muscle weakness, abnormalities of gait (walking pattern) and mobility, multiple myeloma (a type of blood cancer), dementia (impaired ability to remember, think, or make decisions that interferes with everyday activities), and falls. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental processes such as thinking, reasoning or remembering) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment score was 06 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had severe cognitive impairment. (continued on next page)

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.

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

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During a review of Resident 1's MDS Section GG - Functional Abilities and Goals dated 3/26/24, the MDS indicated, . Sit to stand [coded] 04 [Supervision or touching assistance] . Chair/bed-to-chair transfer . 04 [Supervision or touching assistance] .

During an interview on 5/30/24, at 9:55 a.m. with CNA 1, CNA 1 stated Resident 1 had fallen during the night shift. CNA 1 stated Resident 1 was normally able to ambulate (walk) with supervision but was not stable while walking. CNA 1 stated Resident 1's health had declined a couple of days before the fall and he was more agitated than usual.

During an interview on 5/30/24 at 12:37 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 fell during the night shift and was sent to the ACH. LVN 1 stated Resident 1 had a change of condition two days prior to the fall which caused breathing issues, a low oxygen level and agitation. LVN 1 stated the agitation caused Resident 1 to get in and out of bed frequently and unsupervised, so the staff monitored him closely.

During a telephone interview and record review on 6/3/24 at 6:10 a.m. with LVN 2 Resident 1's General Note, dated 5/30/24 at 5:40 a.m. was reviewed. The note indicated, . Resident had an unwitnessed fall on 5/30/24 at 0540 [5:40 a.m.] . Resident was restless during the night and kept trying to get up and get out of bed . Resident has unsteady gaits and was placed on 1 on 1 during the night . Resident was given his prn lorazepam [medication for anxiety] at 0030 [12:30 a.m.] and routine morphine [pain medication] at 0124 [1:24 a.m.] and was effective, resident was calm and rested for about 3 hours and around 0400 [4:00 a.m.] resident started again trying to get out of bed . has facial grimacing of pain and discomfort, writer [LVN 2] administered prn morphine at 0440 [4:40 a.m.] . CNA was 1 on 1 with resident, resident was sleeping in his bed, bed was in lowest position. Per CNA, left resident's side for a split second to help CNA with a pull up to roommate within the same room and heard a loudbang [sic] and resident was already on the floor bleeding from head . another CNA was in room assisting with care to resident's roommate and had the curtain pulled [closed], as CNA walked over to help with the pull up, resident fell . resident noted laying on the floor with blood on his face . [name of ambulance company] arrived at facility and transported resident out to [ACH] at 0600 [6:00 a.m.] . LVN 2 stated she was the charge nurse when Resident 1 fell . LVN 2 stated the evening shift nurse informed her Resident 1 had been agitated, was having difficulty breathing and trying to get out of bed by himself. LVN 2 stated Resident 1 was unstable when standing or walking and she was concerned for his safety, so she assigned CNA 2 to a one-on-one. LVN 2 stated about 3:00 a.m. Resident 1 became restless and was trying to get out of bed. LVN 2 stated Resident 1 could not be left alone safely, so she stayed with him while the CNAs did rounds. LVN 2 stated CNA 2 finished rounds and returned to Resident 1. LVN 2 stated as she walked back to the nurse's station, she heard a loud bang from Resident 1's room. LVN 2 stated she went back to Resident 1's room and the resident was on the floor, lying on his right side with his head near the nightstand and the CNAs were with him. LVN 2 stated Resident 1's hands were on his face and there was blood covering his hands and on the floor. LVN 2 stated she assessed Resident 1, and he had lacerations to the top of his head and right eyebrow. LVN 2 stated CNA 2 told her she had briefly left Resident 1 to help the other CNA with the resident's roommate and had closed the curtain which left Resident 1 out of her sight. LVN 2 stated one-on-one supervision required the staff to stay with the assigned resident only and keep them within view. LVN 2 stated Resident 1 should not have been left alone because his health was declining, he was weaker than usual, restless, and not safe to get up unsupervised.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Order Summary Report (OSR), dated 5/2024, the OSR indicated, . lorazepam oral concentrate 2 mg milligram-unit of measurement]/ml [milliliter-unit of measurement] give 0.25 ml by mouth every 4 hours as needed for M/B [manifested by] restlessness . morphine sulfate . give 0.5 ml by mouth every two hours as needed . During a telephone interview on 6/3/24 at 6:20 a.m. with CNA 2, CNA 2 stated she was assigned to provide Resident 1's one-on-one care when he fell on [DATE]. CNA 2 stated Resident 1 had difficulty breathing and was restless causing him to sit up and lie back down throughout the night. CNA 2 stated she had been assigned Resident 1's one-on-one care the previous night because he was not his usual self. CNA 2 stated she was at Resident 1's bedside and another CNA came into the room and asked for help pulling Resident 1's roommate up in bed. CNA 2 stated they had pulled the curtain closed for privacy, she heard a boom , opened the curtain, and found Resident 1 on the floor. CNA 2 stated Resident 1 had hit his head and was bleeding. CNA 2 stated she was assigned to Resident 1 only and should not have left the Resident unattended. CNA 2 stated Resident 1 was on a one-on-one to keep him safe and prevent falls. CNA 2 stated she had left Resident 1 to help the other CNA because he was lying in bed with his eyes closed and she thought he was asleep. CNA 2 stated she thought Resident 1 would be safe while she briefly helped the other CNA. CNA 2 stated she should have stayed with Resident 1 and asked the CNA to find someone else to help her. CNA 2 stated Resident 1 fell within a minute of her stepping away from him and it was not safe to leave his side. During an interview on 6/3/24 at 12:48 p.m. with the Director of Nursing (DON), the DON stated she had received a phone call in the early morning on 5/30/24 and was informed Resident 1 had fallen while he was on a one-on-one. The DON stated Resident 1 was assessed by the charge nurse who determined the resident needed one-on-one supervision because he was not safe left alone. The DON stated the CNA stepped away from Resident 1 briefly and the resident had fallen. The DON stated Resident 1 was receiving antianxiety and pain medication which side effects increased his risk for falls. The DON stated Resident 1's one-on-one was not effective because the CNA left the resident unattended. The DON stated a one-on-one required the staff to stay with the resident at all times and keep an eye on the resident. The DON stated the facility did not have a policy and procedure (P&P) for the one-on-one process. During a review of a professional reference found at https://www.mayoclinic.org/drugs-supplements/morphine-oral-route/side-effects/drg-20074216 titled Morphine (Oral Route), dated 6/1/24, the reference indicated, . Precautions . Dizziness, lightheadedness, or fainting may occur when you get up suddenly from a lying or sitting position . Side Effects . sleepiness or unusual drowsiness . change in walking and balance . trouble walking . During a review of a professional reference found at https://www.mayoclinic.org/drugs-supplements/lorazepam-oral-route/side-effects/drg-20072296 titled Lorazepam (Oral Route), dated 6/1/24, the reference indicated, . Precautions . This medicine may cause drowsiness, trouble with thinking, trouble with controlling movements . Side Effects . drowsiness . sleepiness . dizziness . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's ACH document titled Hospitalist History & Physical (H&P), dated 5/30/24, the H&P indicated, . Chief Complaint . Patient presents with Difficulty Breathing . Fall . Unwitnessed ground level fall today . on comfort care [form of care that provides symptom relief] measures at skilled nursing facility . patient has been experiencing difficulty breathing since yesterday . unwitnessed ground level fall today resulting in a laceration to his forehead . Caregiver at bedside confirmed that patient is on hospice services [end of life care] at skilled nursing facility . 5/30 0822 [5/30/24 at 8:22 a.m. Laceration repair . During a review of the facility's P&P titled Accidents and Supervision, dated 10/2022, the P&P indicated, . The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices [mobility aids] to prevent accidents . Implementing interventions to reduce hazard(s) and risk(s) . Monitoring for effectiveness and modifying interventions when necessary . Definitions . Accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident . Fall refers to unintentionally coming to rest on the ground, floor or other lower level, but not as a result of an overwhelming external force . Risk refers to any external factor, facility characteristic . or characteristic of an individual resident that influences the likelihood of an accident . Supervision/Adequate Supervision refers to intervention and means of mitigating [lessen the severity of an act] risk of an accident . using specific interventions to try to reduce a resident's risks from hazards in the environment . communicating the interventions to all relevant staff . Assigning responsibility . Ensuring that the interventions are put into action . Development of interim [time between one event and another] safety measures may be necessary if interventions cannot immediately be implemented fully . Resident-directed approaches may include . Implementing specific interventions as part of the plan of care . Monitoring is the process of evaluating the effectiveness of care plan interventions . Modification is the process of adjusting interventions as needed . Monitoring and modification processes include . Ensuring that interventions are implemented correctly and consistently . Supervision is an interventions and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents . Based on the individual resident's assessed needs and identified hazards in the resident environment . During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 12/2007, the P&P indicated, . Based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try and to prevent the resident from falling . The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls . During a review of the facility's P&P titled Assessing Falls and Their Causes, dated 10/2010, the P&P indicated, . Falls are a leading cause of morbidity [having a disease or illness] and mortality [number of deaths that occur in a population] among the elderly in nursing homes . Approximately 50 percent of residents fall annually and 10 percent of these falls result in serious injury . Falling may be related to underlying clinical conditions and functional decline, medication side effects . After an observed or probable fall, the staff will clarify the details of the fall, such as when the fall occurred .