

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 06/10/2025
NAME OF PROVIDER OR SUPPLIER Countryside Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent falls for one of five sampled residents (Resident 3) when Resident 3 who was assessed as being a fall risk, had poor safety awareness and needed to be supervised while ambulating (walking) and the facility did not implement effective interventions to prevent falls, including adequate supervision, consistent with the resident ' s needs, goals and care.</p> <p>This failure resulted in Resident 3 ' s three unwitnessed falls within two weeks, one on 5/9/25, 5/19/25 and 5/22/25 and placed Resident 3 at risk for significant injury.</p> <p>Findings:</p> <p>During a review of Resident 3 ' s admission Record, undated, the admission record indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses which included disorder of bone density (Osteoporosis-weak and brittle bones due to lack of calcium and Vitamin D), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control), dementia (progressive state of decline in mental abilities), abnormalities of gait (manner of walking) and mobility and muscle weakness.</p> <p>During a review of Residents 3 ' s Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive [related to thinking and judgement] and physical function) assessment dated [DATE], indicated Resident 3 ' s Brief Interview of Mental status assessment (BIMS &ndash; assessment of cognitive status for memory and judgement) scored 03 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 3 was severely cognitively impaired.</p> <p>During a concurrent observation and interview on 6/10/25 at 9:22 a.m. with Certified Nursing Assistant (CNA) 1 and Resident 3, in Resident 3 ' s room, resident 3 was lying on another Resident ' s bed fully clothed. Resident 3 has her eyes closed and opened them when spoken to but did not verbally respond. CNA 1 stated she was assigned to provide one on one (1:1) supervision (a designated staff member actively observing an individual resident) for Resident 3 and had to stay with Resident 3 during her shift. CNA 1 stated Resident 3 was on a 1:1 because she had fallen recently. CNA 1 stated Resident 3 had declined in health and had a decreased appetite since her last fall. CNA 1 stated Resident 3 was on hospice care, was weaker and less stable when she walked.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/10/25 at 10:43 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 3 ' s fall care plans were reviewed. Resident 3 ' s fall risk care plan, plan dated 5/10/25, was reviewed. The care plan indicated, . Risk for injury related to impaired cognition and recent fall . 5/9/25 . Interventions . Assess dizziness and balance before ambulation to prevent further falls . Initiate 72-hour neuro checks to monitor for delayed symptoms or changes in mentation . Monitor for signs of delayed injury . Resident 3 ' s fall care plan dated 5/19/25, indicated, . Risk for injury related to fall episode . Interventions . Conduct full-body assessment and neuro checks . Education patient and family on safety precautions and mobility assistance . Notify interdisciplinary team . Provide assistance in repositioning and ensure patient comfort . Reinforce fall prevention measures (red sneaker) . LVN 2 stated Resident 3 had a diagnosis of dementia and would not retain any education or reminders given to her. LVN 2 stated the Red Sneaker Program was the fall prevention program which identifies residents at high risk for falls and interventions to be used for fall prevention. Resident 3 ' s fall care plan dated 5/22/25, indicated, . Risk for injury related to fall while seated in a wheelchair near the nurse ' s station, with skin integrity concerns due to abrasion [scraping of skin] on the dorsal [back side] right wrist measuring 5cm [centimeters-unit of measurement] x [by] 3cm Interventions . Assess surroundings for fall hazards . Supervise mobility and remind resident to request assistance before standing . Cleanse abrasion . Monitor for pain . Notify PT/OT for evaluation . Reinforce safety measures . Resident was placed on Level 3 monitoring . LVN 2 stated Level 3 monitoring meant a CNA provided Resident 3 with direct supervision in the room. Resident 3 ' s fall risk care plan, dated 10/30/24, was reviewed. The care plan indicated, . Potential for Unavoidable Fall and Related Injuries R/T [related to] H/O [history of] falls . Risk Factors: Dx. [diagnosis of] Dementia . Resident 3 ' s care plan dated 3/31/25, indicated, . 1:1 or Level 3 monitoring has been DCd [discontinued] on 3/31/25 per IDT ' s recommendation . Follow up made by IDT on 4/1/25. Continue Level 2 monitoring . LVN 2 stated Resident 3 had been on hospice [end of life care] and was having increased weakness and a decreased appetite. Resident 3 ' s MDS Section GG, dated 3/25/25 was reviewed, the MDS indicated, . Lying to sitting on side of bed [coded 04-Supervision or touching assistance] . Sit to stand [coded 04] . Walk 10 feet [coded 04] . Walk 50 feet with two turns [coded 04] . Walk 150 feet [coded 04] . LVN 2 stated the MDS Section GG, indicated Resident 3 should have supervision while ambulating [walking]. Resident 3 ' s fall risk assessments were reviewed, the assessments indicated, . 5/9/25 . fall risk score 14 . at risk for falls . 5/19/25 . fall risk score 20 . at risk for falls . 5/22/25 . fall risk score 22 . at risk for falls . LVN 2 stated Resident 3 was at high risk for falls due to her dementia and decline in health.</p> <p>During a review of Resident 3 ' s Post Fall IDT Analysis, dated 5/12/25, the IDT note indicated, . Fall Date and Time . 5/9/25 14:24 [2:24 p.m.] . Resident was observed sitting on the floor by the back patio with her back leaning against the wall next to a wheelchair. A staff member had seen the res. [resident] walking outside approximately five minutes prior .</p> <p>During a review of Resident 3 ' s Post Fall IDT Analysis, dated 5/20/25, the IDT note indicated, . Fall Date and Time . 5/12/25 17:10 [5:10 p.m.] . At approximately 5:10 PM, while the LN [Licensed Nurse] was preparing meds [medications] . a loud thud was heard in the HW [hallway] near room [ROOM NUMBER]. Upon assessment, the res. Was found lying supine [on her back] on the floor, with her head raised and one hand reaching for the wall-mounted side rail . Placed on level 2 monitoring .</p> <p>During a review of Resident 3 ' s Post Fall IDT Analysis, dated 5/23/25, the IDT note indicated, . Fall Date and Time . 5/22/25 15:55 [3:55 p.m.] . Resident was sitting in w/c [wheelchair] by the nursing station. Tried to get up and slid to floor . Sustained an abrasion on her rt. [right] wrist. Tx. [treatment] done . Placed on level 3 monitoring .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 6/10/25 at 11:42 a.m. with the Director of Nursing (DON), the facility ' s Red Sneaker Program, dated 12/10/24, was reviewed. The Red Sneaker Program indicated, . Criteria for Inclusion in the Red Sneaker Program . Resident has had a fall in the last 90 days . Resident has a Fall Risk Assessment Score above 10 . Current Red Sneaker Program Care Plan Implementation . Bed in the lowest position . call light within reach . No room/environmental clutter . Anticipate toileting needs for high Risk for Fall Residents . Focus on residents who are High Risk for falls that may be attempting to ambulate independently . Weekly review and as needed review by the DON [Director of Nursing] and IDT of fall prevention program . DON and IDT will make sure appropriate individualized CPs [care plans] and Intervention are in place for new admissions with high FRS [Fall Risk Score] and new fall occurrences as deemed appropriate . The DON stated the program was put into place to help minimize falls in high-risk residents. The DON stated Resident 3 had been on the Red Sneaker Program consistently because she had a history of falling. The DON stated Resident 3 had been on 1:1 supervision for falls until 3/31/25 when the IDT determined the 1:1 supervision could be decreased to Level 2 supervision. The DON stated level 2 supervision meant staff checked on the resident every 15 minutes. The DON stated Resident 3 was on Level 2 supervision/15-minute checks when she fell on 5/9/25, 5/19/25 and 5/22/25. The facility ' s policy and procedure (P&P) titled Safety and Supervision of Residents, undated, was reviewed. The P&P indicated, . individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents . interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents . care team shall target interventions to reduce individual risks . including adequate supervision . Enhanced monitoring as per level by designated staff (CNA or Licensed Nurse) . Level 1-every 30 minutes (checks) . Level 2-every 15 minutes (checks) . Level 3-In-room direct supervision . Monitoring the effectiveness of interventions shall include the following . Ensuring that interventions are implemented correctly and consistently . Evaluating the effectiveness of interventions . Modifying or replacing interventions as needed . Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident ' s assessed needs . The DON was unable to explain why the IDT had determined Resident 3 did not need increased supervision until she fell the third time. The DON stated Level 2 supervision was not effective because Resident 3 had three falls between 5/9/25 and 5/22/25. The DON stated after Resident 3 ' s third fall, on 5/22/25, the IDT met and determined the resident needed to be closely supervised adding Level 3 supervision, so a CNA was assigned to her for direct, in room supervision. The DON stated the root cause of Resident 3 ' s falls were her dementia, confusion and inability to remember education given. The DON reviewed Resident 3 ' s MDS Section GG dated 3/25/25 and stated the MDS indicated Resident 1 needed supervision/touch assistance during ambulation.</p> <p>The facility ' s Policy and Procedure (P&P) titled, Falls and Fall Risk, Managing, dated 12/2007, was reviewed with the DON. The P&P indicated, . the staff will identify interventions related to the resident ' s specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls . If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant . If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions .</p>		