

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  08/12/2025
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)
F 0689  Level of Harm - Actual harm  Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.  (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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(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 - Actual harm  Residents Affected - Few	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure residents received adequate supervision and assistance to prevent falls for one of four sampled residents (Resident 1) when Resident 1 was assessed as being at high risk had poor safety awareness (not paying attention to the dangers around you, a history of self-transferring to get to the bathroom, frequent urination (act of releasing liquid waste that your kidneys make to remove excess fluids and waste products from your body) and needed to be supervised by a staff member during transfer and the facility did not implement individualized interventions to prevent falls, including supervision and addressing the cause of frequent self-transferring attempts, consistent with the resident's needs, goals and care according to the resident assessment and plan of care. These failures resulted in Resident 1 sustaining four unwitnessed falls, two falls on 5/19/25, one fall on 6/16/25 and one fall on 7/16/25. During the fall on 7/16/25, Resident 1 sustained an intertrochanteric fracture (a type of hip fracture [broken bone] where the femur [upper thigh bone] meets the pelvis [ring of bones in the hips and lower back that connects the upper body to the legs]) causing her significant pain, decreased mobility and the resident became bedbound (unable to leave the bed). Resident 1 was not transferred to the emergency department because she was on hospice [specialized form of for end-of-life care] and the Responsible Party's request. During a review of Resident 1's admission Record, undated, the admission record indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included fracture of superior rim (upper edge) of right pubis (pubic bone-a bone that makes up the pelvis), displaced intertrochanteric fracture of left femur, dementia (decline in mental ability severe enough to interfere with daily life), retention of urine (inability to completely empty the bladder), and anxiety disorder (feeling of unease, worry or fear). During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], it indicated Resident 1's Brief Interview of Mental Status assessment (BIMS-assessment of cognitive status for memory and judgement) scored 05 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment score indicated Resident 1 had severe cognitive impairment. During an interview on 8/12/25 at 8:42 a.m. with the Administrator in Training (AIT), the AIT stated Resident 1 was no longer in the facility because she had passed away on hospice on 7/27/25. During an interview on 8/12/25 at 9:26 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 1. CNA 1 stated she was not at the facility when Resident 1 fell and fractured her hip on 7/16/25. CNA 1 stated Resident 1 was a high fall risk and had behaviors of frequently getting up and trying to self-transfer while unsupervised. CNA 1 stated Resident 1 was not safe to transfer without assistance. CNA 1 stated Resident 1 had frequent urgency (sudden, compelling need to urinate) to go to the restroom because she felt like she needed to urinate (pass urine from the body). CNA 1 stated the staff would take Resident 1 to the restroom, and she would ask to go again within minutes of urinating. During an interview on 8/12/25 at 10:27 a.m. with CNA 2, CNA 2 stated she took care of Resident 1 while she was in the facility. CNA 2 stated she would want to toilet all the time. We would take her to the bathroom often, then she would want to go again right away. CNA 2 stated even though staff frequently took Resident 1 to the bathroom, she would try to get up unassisted because she felt like she needed to go again, which increased her fall risk. During a concurrent interview and record review on 8/12/25 at 10:51 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was working when Resident 1 fell on 7/16/25. LVN 1 stated on 7/16/25 around 6:55 a.m., she had just arrived at the facility for her shift and saw Resident 1 in bed. LVN 1 stated she had walked to the nurse's station for report from the night shift and a CNA told her Resident 1 was on the floor. LVN 1 stated she assessed Resident 1 for injuries and Resident 1 complained of pain to her right leg from the back of her knee to her hip. LVN 1 stated Resident 1 appeared to be in pain, so she administered her pain medication. LVN 1 stated Resident 1 was able to move but complained of pain. LVN 1 stated Resident 1 was unable to bear weight on her right leg, so she called hospice and notified them Resident 1 had fallen. LVN 1 stated the hospice nurse came in around 7:30 a.m. for a routine visit and she asked the hospice nurse for an order to X-ray (a painless test that captures images of the structures inside the body) Resident 1's hip but was told to just keep the resident comfortable. LVN 1 stated she was informed by the hospice nurse that because hospice was for end-of-life care, they did not routinely perform X-rays on patients. LVN 1 stated Resident 1's pain continued to worsen and she had facial grimacing [facial expression that show pain] so they requested</p>		