STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056281	A. Building B. Wing	08/23/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation interview and record review, the facility failed to maintain a safe, comfortable, and homelike environment for three out of 12 sampled residents (Residents 22, 29, and 42) when the dining room temperature was below the temperature range of 71 to 81 degrees Fahrenheit (F). This failure placed Residents 22, 29, and 42 at risk to develop symptoms of cold exposure and cold related illnesses. Findings: During a concurrent observation and interview on 8/19/24 at 12:10 p.m. with resident 22 in the hallway, Resident 22 was observed walking toward the dining room. Resident 22 stated she needed a coat. Resident 22 stated it was always cold in the dining room. During a review of Resident 22's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 8/23/24, the AR indicated Resident 22 was admitted on [DATE] with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle weakness, history of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and a history of falling. During a concurrent observation and interview on 8/19/24 at 12:17 p.m. with Resident 29 in the dining room, Resident 29 was observed sitting in her wheelchair, wearing a sweater, eating her meal. Resident 29 stated it was too cold in the dining room. During a review of Resident 29's AR, dated 8/22/24, the AR indicated Resident 29 was admitted on [DATE] with diagnoses of shortness of breath (occurs when you do not get enough oxygen, difficulty breathing), osteoarthritis (occurs when the flexile, protective tissue at the ends of the bones (cartilage) wears down causing pain and stiffness), joint pain and rhabdomyolysis (the breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/13/24, the MDS section C indicated Resident 29 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 29 was cognitively intact. During a concurrent observation and interview on 8/19/24 at 12:18 p.m. with resident 42 in the dining room, Resident 42 was observed dressed, wearing a sweater, sitting in a wheelchair, with oxygen tubing infusing oxygen at 3 liters per minute (L/min) via a nasal cannula into her nose and eating her meal. Resident 42 stated it was too cold in the dining room, even at night. Resident 42 stated she got pneumonia in July 2024. During a review of Resident 42's AR, dated 8/23/24, the AR indicated Resident 42 was admitted to the facility on [DATE], with diagnoses of chronic obstructive pulmonary disease (COPD - a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and asthma (a chronic [long-term] condition where the airways of the lungs become swollen and narrowed making it hard to breathe). During a review of Resident 42's MDS, dated [DATE], the MDS section C indicated Resident 42 had a BIMS score of 12, which suggested Resident 42 was moderately impaired. During a concurrent observation and interview on 8/19/24 at 12:33 p.m. with the Director of Maintenance (DM) in the dining room, the DM was observed checking the temperature of the dining room. The DM temperature readings were observed to be 69 degrees F, 67 degrees F, and 69 degrees F in various areas of the dining room. The DM stated if the door to the dining room was closed prior to serving a meal, it would be cold in the dining room. The DM stated it was important to keep the temperature in the dining room between 71 to 81 degrees F in order to have a home-like environment for the residents who eat in the dining room. During an interview on 8/23/24 at 12:50 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the facility temperature to be within the appropriate range of 71 - 81 degrees F to provide a safe, comfortable home-like environment for the residents. During a review of the facilities policy and procedure (P&P) titled, Homelike Environment, dated (undated), indicated . residents are provided with a safe, clean, comfortable and homelike environment . staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences . the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include . comfortable and safe temperatures (71 degrees F and 81 degrees F) . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of professional reference retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10852811/, titled, Indoor Air Temperature and Agitation of Nursing Home Residents with Dementia, dated 8/2017, indicated . agitation . scores were found to increase significantly when indoor average temperatures deviated from 22.6 degrees C (Celsius) (72.68 degrees F) . agitated behaviors not only affected the person manifesting them but were found to be disruptive for other residents and the delivery of care . agitation can . be potentially reduced by limiting . indoor air temperature variations . aged care providers should ensure that a thermally comfortable environment is provided in nursing homes to enhance comfort and well-being of all occupants . During a review of professional reference retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK535294/#:~:text=Cold%20air%20inflames%20lungs%20and,(COPD)%2C%20and%20infection titled, WHO Housing and Health Guidelines. Low indoor temperatures and insulation, dated 2018, indicated, . cold air inflames lungs and inhibits circulation, increasing the risk of respiratory conditions, such as asthma attacks or symptoms, worsening of chronic obstructive pulmonary disease (COPD) and infection .

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for three of 24 sampled residents (Residents 8, 13, 16) when: 1. Resident 13's care plan was not developed to reflect interventions to address his refusal of medications. This failure had the potential for Resident 13's medical needs to not be met. 2. Resident 8's care plan was not implemented for skin assessments to monitor for skin tears, bruising or wounds. This failure placed Resident 8 at risk for skin injuries. 3. Resident 16's care plan was not implemented for placement of Resident 16's call light within reach of Resident 16. This failure had the potential for Resident 16's needs to not be met and put Resident 16 at risk for injury Findings: 1. During a review of Resident 13's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/21/24, the AR indicated, Resident 13 was admitted from the General Acute Care Hospital (GACH) on 7/26/24 to the facility, with diagnoses including Cerebral Infarction (CVA, Stroke), Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), Anemia (low in iron), Muscle Weakness, Hemiplegia (weakness on one side of the body), Type 2 Diabetes Mellitus (high blood sugar level), and Dysphagia (difficulty swallowing). During a review of Resident 13's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 7/13/24, the MDS indicated Resident 13's Brief Interview for Mental Status (BIMS) score was 0 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/19/24, at 3:00 p.m., with LVN 1, Resident 13's August 2024 Medication Administration Record (MAR), Nursing Progress Note, and Nursing Care Plan were reviewed. The MAR indicated, Resident 13 refused his inhaler on 8/6/24 morning dose, 8/8/24 morning dose, and 8/14/24 morning dose. The MAR indicated, Resident 13 was on LOA on 8/5/24 and did not receive the evening dose of his inhaler. LVN 1 stated she was unable to find any nursing documentation that Resident 13's attending physician was notified of multiple refusals. LVN 1 stated licensed nurses were supposed to notify the physician after multiple episodes of medication refusal and it was not done. LVN 1 stated licensed nurses were supposed to document medication refusals and it was not done. LVN 1 reviewed Resident 13's care plan and stated there was no care plan developed and no interventions were implemented to address Resident 13's medication refusal. LVN 1 stated nurses were supposed to create a care plan for medication refusal and it was not done. LVN 1 stated Resident 13's Chronic Obstructive Pulmonary Disease could worsen and potentially result to hospitalization . During a concurrent interview and record review on 8/20/24, at 10:59 a.m., with the Minimum Data Set Nurse (MDSN), Resident 13's care plan was reviewed. Resident 13's care plan stated, . Resident at times has episodes of refusing care such as nail care, oral care, shower or changing from regular clothes to gown or vice versa . Date Initiated: 8/17/24 . MDSN reviewed Resident 13's care plan and stated there was no specific problem related to episodes of refusing medications and no interventions created to address Resident 13's behavior of refusing medications. MDSN stated the facility failed to follow the policy on care planning, and potentially placed Resident 13 at risk for his COPD to worsen. During a concurrent interview and record review on 8/23/24, at 11:16 a.m., with the DON, Residents 13's nursing care plan was reviewed. The DON stated Residents 13's care plan should have been resident-specific and it was not. The DON stated the care plan drove resident care to ensure resident's care and wishes were being met. The DON stated the facility failed to follow its policy and procedures related to care planning process. The DON stated the failure could potentially result to Resident 13's COPD to worsen. During a review of the facility's document titled, Job Description: Registered Nurse, dated 8/15, the document indicated, . Essential Job Duties . Develop individualized plan of care in collaboration with the resident/responsible party and interdisciplinary care team . During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, dated 8/15, the document indicated, . Assist a Supervisor as directed and participate in developing and implementing a written care plan for individual residents that addresses the needs of the resident . During a review of the facility's policy and procedure (P&P) titled Care Planning - Interdisciplinary Team, undated, the P&P indicated, . The interdisciplinary team is responsible for the development of resident care plans . 2. Comprehensive, person-centered care plans are based on resident assessments and develop by an interdisciplinary team (IDT) . 48739 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 8/19/24 at 9:50 a.m. with Resident 8 in Resident 8's room, Resident 8 was observed dressed in bed with a sling over Resident 8's arm. Resident 8 adjusted her sling and a quarter size wound with reddened edges was observed under Resident 8's forearm, near the elbow. Resident 8 stated staff was not treating her wound. Resident 8 stated staff did not check her skin when she showered. During a review of Resident 8's AR, dated 8/23/24, the AR indicated Resident 8 was admitted from acute hospital on 1/27/22 to the facility with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), peripheral vascular disease (the reduced circulation of blood to the arms or legs), protein-calorie malnutrition (inadequate intake of food), basal cell carcinoma (a form of skin cancer) of the skin, and changes in skin texture. During a review of Resident 8's MDS, dated [DATE], the MDS section C indicated resident 8 had a BIMs score of 8, which indicated Resident 8 was moderately impaired. During a concurrent observation and interview on 8/22/24 at 11:10 a.m. with Resident 8 in the dining room, Resident 8 was observed to have a band-aid covering her wound on her right forearm, near her elbow. Resident 8 stated she had not received care for her wound. Resident 8 stated she had a band-aide in her dresser drawer and had applied the band-aide to her wound herself. During a concurrent interview and record review on 8/22/24 at 12:59 p.m. with the Registered Nurse Supervisor (RNS), Resident 8's Task Shower Log, dated August 2024 was reviewed. The Task Shower Log indicated Resident 8 had a shower or bath seven times from 8/10/24 to 8/18/24. The RNS stated Resident 8 had a shower or bath on 8/9, 8/11, 8/12, 8/13, 8/16, 8/17, and 8/18/24. The RNS stated there were no wounds documented in Resident 8's medical record. The RNS stated she did not know Resident 8 had a wound to her right forearm. The RNS stated the Certified Nursing Assistant (CNA) would do a skin check during the resident's shower or bath. The RNS stated the CNA would notify the nurse if a resident was refusing a shower and if there were any wounds observed on the resident during the resident's bath or shower. During a concurrent interview and record review on 8/22/24 at 1:10 p.m. with the RNS, Resident 8's Care Plan (CP), dated 8/22/24 was reviewed. The CP indicated . weekly skin assessment, notify MD (Medical Doctor) for any skin issues; skin tears, bruising, wounds, etc. , initiated 3/27/24. No care plan was in place for Resident 8's wound to her right forearm. The RNS stated Resident 8 did not have a care plan in place for wound care to her right forearm. During a concurrent interview and record review on 8/22/24 at 1:25 p.m. with the RNS, Resident 8's Skin Assessment with Shower Day (Log), dated 8/8/24 and 8/12/24 were reviewed. The Log indicated resident 8 had no documentation of wounds on 8/8/24 or 8/12/24. The RNS stated no wounds were documented on 8/12/24 and Resident 8 refused a shower on 8/8/24. The RNS stated there were no other skin assessment logs found for Resident 8 during her bath or shower days for the month of August. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/22/24 at 1:28 p.m. with LVN 1, LVN 1 stated she was not aware of a wound on Resident 8's right arm. LVN 1 stated she had just checked Resident 8, and Resident 8's wound was from an old skin tear on her right forearm. LVN 1 stated during resident showers, CNAs would do skin checks for wounds or bruises and notify the nurse if there was a wound or bruising observed. LVN 1 stated she was not notified of any wounds or skin tears on Resident 8. During an interview on 8/22/24 at 1:46 p.m. with CNA 2, CNA 2 stated resident skin assessments were done all the time during showers, activities of daily living (ADL)s, brief changes, or whenever the resident had hands-on care. CNA 2 stated the CNAs would let the nurse know if a resident had bruises or skin tears. CNA 2 stated she had Resident 8 today. CNA 2 stated Resident 8 stated she did not know what happened to her right arm. During an interview on 8/23/24 at 12:50 p.m. with the DON, the DON stated her expectations were for staff to monitor the residents and modify the resident's care plan if needed. The DON stated her expectations were for staff to perform resident skin checks every day during ADLs and two times per week during resident showers. The DON stated her expectations were for staff to complete a skin check form indicating if there was a wound, where the wound was, and notify the nurse if there was a wound or bruising. During a review of the facility job description titled, Certified Nurse Aide, (CNA), dated 9/2014, indicated, . essential job duties . provide resident care as directed by care plan and/or nursing staff . participate in collecting data needed for the accurate completion of the MDS and the plan of care . During a review of the facility P&P titled, Bath, Shower/Tub, dated (undated), indicated, . the purposes of this procedure are to . observe the condition of the resident's skin . observe skin for any rashes, reddened areas, swelling etc. documentation . all assessment data (e.g., any reddened areas, sores, etc., on the resident's skin) obtained during the shower/tub bath . reporting . notify the physician of any skin areas that may need to be treated . During a review of the facility P&P titled, Care Plans, Comprehensive Person-Centered, dated (undated), indicated, . a comprehensive, person-centered care plan that includes measurable objectives . is developed and implemented for each resident . the interdisciplinary team (IDT), in conjunction with the resident . develops and implements a comprehensive, person-centered care plan for each resident . the comprehensive, person-centered care plan . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical well-being . assessments of residents are ongoing . revised as . resident's condition changes . During a review of the facility P&P titled, . Care Planning - Interdisciplinary Team, dated (undated), indicated, . comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team (IDT) . the IDT includes . a registered nurse with responsibility for the resident . a nursing assistant with responsibility for the resident . 3. During a concurrent observation and interview on 8/19/24 at 3:37 p.m. with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 16 in Resident 16's room, Resident 16 was observed dressed, laying in her bed. Resident 16's call light was observed on the far side of Resident 16's dresser out of Resident 16's reach. Resident 16 stated she wanted to be covered. Resident 16 stated she was not able to reach her call light. Resident 16 stated she would move to the end of her bed and call for help if she needed something. During a review of Resident 16's AR, dated 8/22/24, the AR indicated Resident 16 was admitted from a nursing facility on 9/15/22 with diagnoses of dementia, history of falling, fracture of right femur (a break in the bone of the thigh), and protein-calorie malnutrition. During a review of Resident 16's MDS, dated [DATE], the MDS section C indicated Resident 16 had a BIMs score of 2, which indicated Resident 16 had severe cognitive impairment. During an interview on 8/19/24 at 3:41 p.m. with the Activity Assistant (ACTA), the ACTA stated Resident 16's call light was on Resident 16's dresser out of Resident 16's reach. The ACTA stated Resident 16 would not use her call light. During an interview on 8/19/24 at 3:54 p.m. with CNA 3, CNA 3 stated sometimes Resident 16 would use the call light. CNA 3 stated Resident 16 could get up to get the call light. CNA 3 stated Resident 16 did not want the call light on her bed. CNA 3 stated Resident 16 wanted the call light on the dresser. During a concurrent interview and record review on 8/22/24 at 2:57 p.m. with the MDSN, Resident 16's CP, dated 8/22/24 was reviewed. The CP indicated Resident 16 was at risk for falls, the MDSN stated Resident 16's intervention to prevent falls was to keep call light within reach and encourage Resident 16 to use the call light when needed. During an interview on 8/22/24 at 1:38 p.m. with the RNS, the RNS stated Resident 16's call light should have been on Resident 16's bed within reach, whether the Resident 16 was awake or not awake. The RNS stated if residents did not want the call light on their bed the call light should still be next to the resident within reach. The RNS stated it was the facility's policy for residents to have the call light within reach of the resident. The RNS stated if the resident's call light was not next to the resident, the CP was not being followed. During an interview on 8/23/24 at 12:50 p.m. with the DON, the DON stated her expectation was for resident's call lights to be next to the resident or on the dresser, within reach at all times. The DON stated if the CP dictated the call light was to be within reach of the resident and the CP was not followed, the resident would be at risk for an accident or fall. The DON stated her expectation was resident's CPs were individualized and had interventions and monitoring for falls and call light placement. During a review of the facility's P&P titled, Call System, Residents, dated (undated), indicated, . residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station . if the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication . is provided and documented in the care plan . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Safety and Supervision of Residents, dated (undated), indicated, . individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents .the care team shall target interventions to reduce individual risks . including . assistive devices . ensuring interventions are implemented correctly and consistently . During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated (undated), indicated, . a comprehensive, person-centered care plan . is developed and implemented for each resident . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical . well-being . includes . which professional services are responsible for each element of care . assessments of residents are ongoing and care plans are revised as . residents' conditions change .

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 44899 Based on interview and record review, the facility failed to provide services which met professional standards of practice for 7 of 24 sampled residents (Residents 13, 40, 42, 100, 101, 102, and 151) when: 1. Registered Nurse (RN) 1 and Licensed Vocational Nurse (LVN) 1 failed to explain the medication names and indications to Residents 40, 100, 101, 102, and 151 during medication administration. This failure had the potential to place Residents 40, 100, 101, 102, and 151 at risk of receiving the wrong medication and experience unnecessary side effects. 2. The facility failed to notify the Attending Physician of Resident 13's ongoing refusal of Fluticasone-Salmeterol (medication to prevent inflammation and narrowing of airway) inhaler. This failure had the potential to place Resident 13 to not receive appropriate care and not to be able to attain the highest well-being. 3. The facility failed to take a current Oxygen Saturation (O2 sat - the amount of oxygen circulating in the blood) and respiration (breathing) assessments on Resident 42 prior to transporting Resident 42 to the hospital for shortness of breath (SOB). This failure had the potential to place resident 42 at risk to not receive the appropriate level of care and have their needs go unmet. Findings: 1. During a medication pass observation on 8/20/24, at 8:29 a.m., inside Resident 100's room, LVN 1 administered Vitamin B Complex Vitamins (medication for iron deficiency) 1000 microgram (MCG - unit of measurement) one tablet, Multiple Vitamin (dietary supplement) one tablet, Niacin (dietary supplement) 500 milligram (MG - unit of measurement) two tablets (1000 MG), Pantoprazole Sodium (medication to prevent heartburn) 40 MG one tablet, and Amlodipine Besylate (medication to lower blood pressure) 5 MG one tablet, without explaining the medications and indications to Resident 100. During a review of Resident 100's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/21/24, the AR indicated, Resident 100 was admitted from an acute care hospital on 8/8/24 to the facility, with diagnoses including Hypertension (high blood pressure), Anemia (low iron), Gastro-esophageal Reflux Disease (GERD - a condition that occurs when stomach acid flows back up into the esophagus, heartburn), Neuropathy (pain cause by damage nerves) and Muscle Weakness. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 100's Physician Order Summary (POS), dated 8/21/24, the POS indicated, . Vitamin B Complex Vitamins 1000 MCG tablet. Give one tablet by mouth one time a day related to IRON DEFICIENCY ANEMIA . Order Date 8/8/24 . Multiple Oral Tablet . Give one tablet by mouth one time a day for dietary supplement . Order Date 8/8/24 . Niacin Oral Tablet 500 MG. Give two tablets (1000 MG) by mouth one time a day for dietary supplement . Order Date 8/8/24 . Pantoprazole Sodium Oral Tablet Delayed Release 40 MG. Give one tablet by mouth one time a day related to GERD . Order Date 8/8/24 . Amlodipine Besylate Oral Tablet 5 MG. Give one tablet by mouth one time a day related to ESSENTIAL HYPERTENSION . Order Date 8/8/24 . During a medication pass observation on 8/20/24, at 8:35 a.m., inside Resident 101's room, LVN 1 administered Amlodipine Besylate 10 MG one tablet and Carbidopa-Levodopa (medication for Parkinson's Disease, a disease of the brain and spinal cord, symptoms include muscle rigidity and tremors) 25-100 MG one tablet, without explaining the medications and indications to Resident 101. During a review of Resident 101's AR, dated 6/21/24, the AR indicated, Resident 101 was admitted from an acute care hospital on 8/8/24 to the facility, with diagnoses including Hypertension and Parkinson's Disease. During a review of Resident 101's POS, dated 8/21/24, the POS indicated, . Amlodipine Besylate Oral Tablet 10 MG. Give one tablet by mouth one time a day related to ESSENTIAL HYPERTENSION . Order Date 8/8/24 . Carbidopa-Levodopa Oral Tablet 25-100 MG. Give 1 tablet by mouth three times a day relate dot PARKINSON'S DISEASE . Order Date 8/8/24 . During a medication pass observation on 8/20/24, at 8:43 a.m., inside Resident 40's room, LVN 1 administered Sennosides-Docusate Sodium (medication to prevent constipation) 8.6-50 MG two tablets, Amiodarone Hydrochloride (medication to lower blood pressure) 200 MG one tablet, Aspirin (medication to prevent blood clot or heart attack) 81 MG one tablet, Baclofen (medication to prevent muscle spasm) 5 MG one tablet, Sertraline Hydrocholoride (medication for depression or anxiety) 100 MG one tablet, and Tramadol Hydrochloride (medication for pain) 50 MG one tablet without explaining the medications and indications to Resident 40. During a review of Resident 40's AR, dated 8/21/24, the AR indicated, Resident 40 was admitted from an acute care hospital on 7/2/24 to the facility, with diagnoses including Cerebrovascular Disease (stroke), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Hypertension (define), Muscle Spasm (sudden involuntary movement in one or more muscles, muscle cramp), History of Falling, and Atrial Fibrillation (Afib, is an irregular and often very rapid heart rate). During a review of Resident 40's POS, dated 8/21/24, the POS indicated, . Sennosides-Docusate Sodium 8.6-50 MG. Give two tablets by mouth two times a day for Constipation . Order Date 7/2/24 . Amiodarone Hydrochloride Oral Tablet 200 MG. Give one tablet by mouth one time a day related to ATRIAL FIBRILLATION . Order Date 8/5/24 . Aspirin Oral Tablet Chewable 81 MG. Give one tablet by mouth one time a day related to ACUTE EMBOLISM (blood clot) . Order Date 7/2/24 . Baclofen Oral Tablet 5 MG. Give one tablet by mouth two times a day related to MUSCLE SPASM . Order Date 7/2/24 . Sertraline Hydrocholoride Oral Tablet 100 MG. Give one tablet by mouth one time a day related to DEPRESSION . Order Date 7/9/24 . Tramadol Hydrochloride Oral Tablet 50 MG. Give one tablet by mouth two times a day for distressing pain . Order Date 7/31/24 . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/20/24, at 11:05 a.m., with LVN 1, LVN 1 stated she did not explain the medications and indications when she gave the medications to Residents 40, 100, and 101. LVN 1 stated facility Residents has the right to know the medications they are receiving, and she failed to inform them (residents). During a medication pass observation on 8/20/24, at 11:11 a.m., inside Resident 151's room, RN 1 administered Gabapentin (medication for pain or discomfort) 600 MG half tablet (300 MG) without explaining the medication and indication to Resident 151. During a review of Resident 151's AR, dated 8/21/24, the AR indicated, Resident 151 was admitted from an acute care hospital on 8/14/24 to the facility, with diagnoses including Morbid Obesity (overweight), History of Falling, Fracture of Left Radius (break in the arm near the wrist area), and Type 2 Diabetes Mellitus (abnormal or high blood sugar). During a review of Resident 151's POS, dated 8/21/24, the POS indicated, . Gabapentin oral tablet 600 MG. Give 0.5 by (300 MG) tablet by mouth three times a day for [nerve] pain . Order date 8/14/24 . During a medication pass observation on 8/20/24, at 11:23 a.m., inside Resident 102's room, RN 1 administered Divalproex Sodium Delayed Release (medication for mood disorder) 250 MG one tablet without explaining the medication and indication to Resident 151. During a review of Resident 102's AR, dated 8/21/24, the AR indicated, Resident 151 was admitted from an acute care hospital on 8/15/24 to the facility, with diagnoses including Atrial Fibrillation (irregular heart beat), Bipolar Disorder (a mental condition marked by alternating periods of elation and depression), and Hypertension. During a review of Resident 102's POS, dated 8/21/24, the POS indicated, . Divalproex Sodium Delayed Release 250 MG. Give one tablet three times a day related to UNSPECIFIED MOOD DISORDER . Order date 8/16/24 . During an interview on 8/20/24, at 11:30 a.m., with RN 1, RN 1 stated she did not explain the medications and indications when she gave the medications to Residents 102 and 151. RN 1 stated facility Residents has the right to know the medications they are receiving, and she failed to inform the residents. During an interview on 8/23/24, at 10:55 a.m. with the Director of Nursing (DON), the DON stated RN 1 and LVN 1 should explain the medications and their use prior to medication administration. The DON stated facility Residents have the right to know the medications they are receiving at all times. The DON stated RN 1 and LVN 1 failed to follow the facility's expectations and assigned responsibilities during medication pass. During a review of the facility's document titled, Job Description: Registered Nurse, dated 8/15, the document indicated, . Essential Job Duties . Assure that effective quality nursing care is delivered which is outcome focus through utilization of the nursing process . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, dated 8/15, the document indicated, . Prepare and administer medications under the direction of a supervisor and as ordered by the physician in accordance with nursing standards and facility policies . During a review of the facility's policy and procedure (P&P) titled, Administering Medications, undated, the P&P indicated . Medications are administered in a safe and timely manner, and as prescribed . 5. Medication administration times are determined by resident need and benefit . c. honoring resident choices and preferences, consistent with his or her care plan . During a review of the facility's P&P titled, Resident Rights, undated, the P&P indicated . Employees shall treat all residents with kindness, respect and dignity . p. be informed of, and participate in, his or her care planning and treatment . 2. During a review of Resident 13's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/21/24, the AR indicated, Resident 13 was admitted from acute hospital on 7/26/24 to the facility, with diagnoses including Cerebral Infarction (CVA, Stroke), Chronic Obstructive Pulmonary Disease (COPD - is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), Anemia (low in iron), Muscle Weakness, Hemiplegia (weakness on one side of the body), Type 2 Diabetes Mellitus (high blood sugar level), and Dysphagia (difficulty swallowing). During a concurrent observation and interview, on 8/19/24, at 2:54 p.m., with Licensed Vocational Nurse (LVN) 1, in front of the nurse station, LVN 1 was observed holding Resident 13's Fluticasone-Salmeterol inhaler. LVN 1 stated the inhaler opened date was 7/28/24 and 41 doses left in the container. LVN 1 stated the physician order was to administer twice a day and if it's given as ordered, the remaining doses should be 16 doses and not 41 doses. During a concurrent interview and record review on 8/19/24, at 3:00 p.m., with LVN 1, Resident 13's August 2024 Medication Administration Record (MAR) and Nursing Progress Note were reviewed. The MAR indicated, Resident 13 refused his Fluticasone-Salmeterol inhaler on 8/6/24 morning dose, 8/8/24 morning dose, and 8/14/24 morning dose. The MAR indicated, Resident 13 was on LOA on 8/5/24 and did not receive the evening dose of his inhaler. LVN 1 stated she was unable to find any nursing documentation that Resident 13's attending physician was notified of multiple refusals. LVN 1 stated licensed nurses were supposed to notify the physician after multiple episodes of medication refusal and it was not done. LVN 1 stated licensed nurses were supposed to document medication refusals and it was not done. LVN 1 stated Resident 13's Chronic Obstructive Pulmonary Disease could worsen and potentially result to hospitalization . During an interview on 8/23/24, at 11:03 a.m. with the Director of Nursing (DON), the DON stated licensed nurses were supposed to notify the Attending Physician after three or more episodes of medication refusal. The DON stated her expectation was for the licensed nurses to document any refusal of medications and to report multiple episodes of medication refusal to the attending physician for further guidance. The DON stated licensed nurses failed to follow the facility's P&P related to refusing and/or discontinuing care or treatment. The DON stated the lack of follow-up and communication between the licensed nurses and the attending physician could result to Resident 13's COPD to worsen. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's Physician Order Summary(POS), dated 8/21/24, the POS indicated, . Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 250-50 Micro Grams Actuator (MCG/ACT - unit of measurement) . Order date 7/26/24 . During a review of the facility's document titled, Job Description: Registered Nurse, dated 8/15, the document indicated, . Essential Job Duties . Assure that effective quality nursing care is delivered which is outcome focus through utilization of the nursing process . During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, dated 8/15, the document indicated, . Prepare and administer medications under the direction of a supervisor and as ordered by the physician in accordance with nursing standards and facility policies . During a review of the facility's policy and procedure (P&P) titled, Requesting, Refusing and/or Discontinuing Care or Treatment, undated, the P&P indicated . 10. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request . 48739 3. During a concurrent observation and interview on 8/22/24 at 11:02 a.m. with Resident 42 in the dining room, Resident 42 was observed dressed in a sweater sitting in her wheelchair with oxygen tubing infusing oxygen at 3 liters per minute (3 L/m) through her nose. Resident 42 stated she went to the hospital last week due to her feeling like she could not get enough air when she breathed. Resident 42 stated she requested an inhaler and was told by the nurse she would have to wait for seven hours to get an inhaler or go to the hospital. Resident 42 stated she requested to be sent to the hospital. During a review of Resident 42's AR, dated 8/23/24, the AR indicated Resident 42 was admitted to the facility from an acute care hospital on 4/24/24, with diagnoses of chronic obstructive pulmonary disease (COPD - a condition caused by damage to the airways or other parts of the lung that blocks airflow and makes it hard to breathe) and asthma (a chronic [long-term] condition where the airways of the lungs become swollen and narrowed making it hard to breathe). During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/30/24, the MDS section C indicated Resident 42 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 42 was moderately impaired. During a review of Resident 42's eINTERACT Change in Condition Evaluation (COC), dated 8/14/24, the COC indicated, . change in condition, symptoms, or signs . shortness of breath . started on 8/14/24 . pertinent diagnosis . COPD . are these the most recent vital signs taken after the change in condition occurred? . Yes . respiration 18, date 8/3/24 . is the respiratory rate > 28 per minute or < 10 per minute? . No . most recent temperature . 97.2, date 8/3/24, route: forehead . is the oral temperature > 100.5 . No . most recent O2 sats . O2 sats 96%, date 8/3/24, Method: room air . is the oxygen saturation < 90%? . No . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/22/24 at 1:21 p.m. with the Registered Nurse Supervisor (RNS), Resident 42's Progress Note SBAR - Change of Condition (SBAR), dated 8/14/24 was reviewed. The SBAR indicated Resident 42's vital sign assessment (vitals - a measurement of the body's most essential functions. They include heart rate [how fast the heart is beating], body temperature, respiratory rate [how fast a person is breathing], blood pressure [the amount of force the heart uses to pump blood through the arteries], and oxygen saturation) included a respiration reading of 18 dated 8/3/24 and O2 sat reading of 96% dated 8/3/24. The RNS stated the assessment of Resident 42's respirations and O2 sat was from an 8/3/24 assessment. The RNS stated there was no documentation of vital assessment for Resident 42's respirations or O2 sat prior to sending the resident to the hospital on 8/14/24. The RNS stated staff should have checked blood pressure (b/p), respirations, O2 sat and temperature prior to transporting Resident 42 to the hospital. The RNS stated staff should have checked Resident 42's O2 sat and respirations on 8/14/24, especially for a complaint of shortness of breath. The RNS stated it was part of the facility's policy and procedure (P&P) that all vitals were taken prior to transporting a resident for resident safety. During an interview on 8/23/24 at 12:50 p.m. with the DON, the DON stated her expectation was staff would check all vital signs on residents prior to transferring the residents to the hospital. During a review of the facility P&P titled, Resident Examination and Assessment, dated (undated), indicated, . the purpose of this procedure is to examine and assess the resident for any abnormalities in health status . vital signs: . blood pressure . pulse . respirations . and temperature . notify the physician of any abnormalities . abnormal vital signs . labored breathing . During a review of the facility P&P titled, Acute Condition Changes - Clinical Protocol, dated (undated), indicated, . the physician will help identify individuals with a significant risk for having acute changes of condition . someone with unstable vital signs . the nurse shall assess and document/report the following baseline information . vital signs . During a review of the facility P&P titled, . Transfer or Discharge, Facility-Initiated, dated (undated), indicated, . an immediate transfer or discharge is required by the resident's urgent medical needs . should a resident be transferred or discharged for any reason, the following information is communicated to the receiving facility or provider . recent vital signs . to ensure a safe and effective transition of care .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 48739 Based on observation, interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medications (medications which affect the mind, emotions, and behavior) for one of seven residents (Resident 39) when Resident 39 was given divalproex (an anticonvulsant medication used to treat seizures [a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness]) without a specific condition diagnosed and documented in Resident 39's clinical record. This failure had the potential for Resident 39 to receive unnecessary psychotropic medications and placed Resident 39 at an increased risk for developing adverse (harmful) side effects due to taking divalproex. Findings: During a concurrent observation and interview on 8/19/24 at 9:35 a.m. with Certified Nursing Assistant (CNA) 6 in Resident 39's room, Resident 39 was observed sleeping in her bed with the head of her bed elevated. Bruising was observed on Resident 39's forehead, bridge of Resident 39's nose and around Resident 39's left eye. CNA 6 stated she was a sitter for Resident 39. CNA 6 stated she was informed Resident 39 fell but did not know specifics of how she fell . During an interview on 8/19/24 at 3:21 p.m. with Resident 39's Responsible Party (RP), the RP stated Resident 39 fell out of bed. During a record review of Resident 39's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 8/16/24, the AR indicated Resident 39 was admitted to the facility from an acute care hospital on 2/29/24, with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), muscle weakness, unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition, and unspecified mood (affective) disorder. During a review or Resident 39's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/4/24, the MDS section C indicated Resident 39 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of six (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 39 was severely impaired. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/22/24 at 8:34 a.m. with the Pharmacist Consultant (PharmD), Resident 39's Order Summary Report (OSR), dated 8/22/24 was reviewed. The OSR indicated Resident 39 was started on divalproex on 8/5/24 for . unspecified mood (affective) disorder m/b (manifested by) irritability and being short tempered AEB (as evidenced by) using abusive language and threatening behavior during ADL (activities of daily living) care . The PharmD stated Resident 39 was started on divalproex on 8/5/24 for a mood disorder (a mental health condition that primarily affects your emotional state). The PharmD stated Resident 39's diagnoses were cognitive disorder (problems with a person's ability to think, learn, remember, use judgement, and make decisions) and mood disorder. The PharmD stated divalproex was being used off label for mood disorders. The PharmD stated divalproex was indicated for diagnoses of bipolar (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and mania (a condition in there is a period of abnormally elevated, extreme changes in a person's mood or emotions, energy level or activity level). The PharmD stated divalproex was being used as an anti-psychotic. The PharmD stated there were other medications that could have been used on-label for Resident 39's diagnoses. During a review of Resident 39's Medication Administration Record (MAR), dated 6/1/24-6/30/24, the MAR indicated non-pharmacological interventions used by staff for periods of persistent irritability and aggression were documented as effective (e). During an interview on 8/23/24 at 12:50 p.m. with the Director of Nursing (DON), the DON stated divalproex was being used as a mood stabilizer. The DON stated she was aware the indication for divalproex use was for seizures. The DON stated her expectation was for residents to have a specific diagnosis before giving psychotropic medications. During a review of the facility policy and procedure (P&P) titled, Psychotropic Medication Use, dated (undated), indicated, . residents will not receive medications that are not clinically indicated to treat a specific condition . medications not classified as anti-psychotic, anti-depressant, anti-anxiety, and hypnotic medications are not prescribed or administered as a substitution for another psychotropic medication unless there is a documented clinical indication consistent with clinical standard of practice . non-pharmacological approaches are used (unless contraindicated) to minimize the need for medications .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48739 Based on observations, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when the high temperature dishwasher did not reach the required temperature during the wash cycle of 155 degrees Fahrenheit (F). This failure had the potential to place 52 out of 55 highly susceptible residents who received food from the kitchen at risk for foodborne illness (illness caused by ingestion of contaminated food or beverages) due to cross-contamination (the transfer of harmful substances or disease-causing microorganisms). Findings: During a concurrent observation and interview on 8/19/24 at 8:22 a.m. with Dietary Aide (DA) 1 in the kitchen, DA 1 was observed washing dishes in a high temperature dishwasher. The temperature reading during the wash cycle read below 150 degrees F. DA 1 stated the temperature during the washing cycle read 145 degrees F. DA 1 stated the temperature during the wash cycle should have read above 135 degrees F. During an interview on 8/19/24 at 8:34 a.m. with DA 1, DA 1 stated the correct temperature reading for a high temperature dish washer was 150 degrees F and above during the wash cycle and 180 degrees F and above during the rinse cycle. DA 1 stated if the dishwasher did not reach the appropriate temperature, she would change the water and clean the drain to the dishwasher. DA 1 stated she would re-wash the three racks of dishes that were washed prior to changing the water and cleaning the drain. Observed DA 1 re-wash a rack of dishes. DA 1 stated the temperature reading of the dishwasher was 170 degrees F during the wash cycle and 185 degrees F during the rinse cycle. DA 1 stated it was important for the dishwasher to reach the correct temperature to make sure the dishes were clean. DA 1 stated residents could get sick if the dishes were not clean. During an interview on 8/21/24 at 10:21 a.m. with [NAME] (CK) 1, CK 1 stated he would wash dishes when needed. CK 1 stated it was important for the dishwasher temperature to reach the appropriate temperature. CK 1 stated residents could get sick if the dishes were not washed correctly. CK1 stated if the dishwasher did not reach the appropriate temperature, he would notify the supervisor and call the dishwasher machine distributor for maintenance. During an observation on 8/21/24 at 10:24 a.m. in the kitchen, the dishwasher data plate was observed. The dishwasher data plate indicated the minimum wash temperature was 155 degrees F and the minimum rinse temperature was 180 degrees F. During an interview on 8/21/24 at 10:25 a.m. with the Certified Dietary Manager (CDM), the CDM stated dishes needed to be washed at the correct temperature due to being a sanitation issue and infection control issue. The CDM stated if the dishwasher did not reach the appropriate temperature, residents could get sick. The CDM stated if the dishwasher was broken, staff were trained to use the three compartment sink to manually wash dishes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056281	A. Building B. Wing	08/23/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/21/24 at 3:51 p.m. with the Registered Dietician (RD), the RD stated her expectation was for the dishwasher to wash dishes at the correct temperature. The RD stated staff would inform maintenance if the dishwasher was not washing at the correct temperature. The RD stated the CDM was responsible for making sure the kitchen was clean and kitchen equipment was in working order. During a review of the facility policy and procedure (P&P) titled, Dishwashing, dated (undated), indicated, . all dishes will be properly sanitized through the dishwasher. The dishwasher will be kept clean and in good working order . the dishwasher will run the dish machine until the temperature is within the manufacturer's recommendations . if you cannot achieve this temperature, alert the FNS Director or cook who will alert the Maintenance Department and stop washing dishes . high-temperature machine: . use the machine at a temperature of 150 degrees F to 165 degrees F or higher for the wash and 180 degrees F or above for the rinse. If you do not achieve the proper temperature, resort to the MANUAL METHOD OF DISHWASHING . During a review of the professional reference titled, FDA Food Code Annex 3. Public Health Reasons/Administrative Guidelines (FDA Food Code), dated 2022, the FDA Food Code section 4-204.113, Warewashing Machine, Data Plate Operating Specification indicated, . the data plate provides the operator with the fundamental information needed to ensure that the machine is effectively washing, rinsing, and sanitizing equipment and utensils . During a review of the professional reference titled, FDA Food Code Annex 3. Public Health Reasons/Administrative Guidelines (FDA Food Code), dated 2022, the FDA Food Code section 4-204.115 Warewashing Machines, Temperature Measuring Devices indicated, . the requirement for the presence of a temperature measuring device in each tank of the warewashing machine is based on the importance of temperature in the sanitation step. In hot water machines, it is critical that minimum temperatures be met at the various cycles so that the cumulative effect of successively rising temperatures causes the surface of the item being washed to reach the required temperature for sanitation .

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	056281	A. Building B. Wing	08/23/2024

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. 44899 Based on observation during the survey period of 8/19/24 through 8/23/24, the facility failed to ensure each bedroom accommodated no more than four residents in three of 19 rooms (Rooms' 1, 2, and 14). This failure had the potential to adversely effect care provided to residents. Findings: During the initial tour on 8/19/24 at 10:30 a.m., the following rooms had more than four residents in each bedroom. Although the bedrooms accommodated more than four residents, each room met the particular needs of each residents. There was sufficient room for nursing care and for residents to ambulate. There was adequate closet and storage space. Bedside stands were available for each residents. Wheelchair and toilet facilities were accessible. The health and safety of residents would not be adversely affected by the continuance of this waiver. Room Number Number of Beds 1 6 2 6 14 6 Recommend waiver continue in effect. HFES Signature Date Request waiver continue in effect. _____ Facility Administrator Signature Date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056281	A. Building B. Wing	08/23/2024

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

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 48739 Based on observation, interview and record review, the facility failed to maintain an effective pest control program to prevent the presence of pests when flies were observed in the kitchen area on 8/20/24 and 8/21/24. This failure had the potential to lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) for residents who ate food from the kitchen. Findings: During an observation on 8/20/24 11:02 a.m. in the kitchen, a fly was observed flying around the food serving area. During a concurrent observation and interview on 8/21/24 at 10:25 a.m. with the Certified Dietary Manager (CDM) in the kitchen, two flies were observed flying in the kitchen by the food serving area and dishwasher area. The CDM stated there was a fly fan (Air Curtain - a mechanical device which produces a controlled plane of moving air across the opening to prevent the entrance of flying insects and other airborne contaminants) at the back entrance of the kitchen. The CDM stated the kitchen did not have a fly light trap to attract and get rid of flies. The CDM stated pest control was scheduled at the facility once a month. The CDM stated flies were an infection control issue. The CDM stated residents could get sick. During an interview on 8/21/24 at 3:51 p.m. with the Registered Dietician (RD), the RD stated her expectation was for there to be no flies or pests in the kitchen. The RD stated residents could get sick. The RD stated the CDM was responsible for making sure the kitchen was clean and no pests were in the kitchen. During a review of the facility's policy and procedure (P&P) titled, Policies and Practices - Infection Control, dated, (undated), indicated, . this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections . the objectives of our infection control policies and practices are to . maintain a safe, sanitary, and comfortable environment . No P&P for pest control or kitchen sanitation was received from the facility as requested. During a review of the professional reference titled, FDA Food Code 2022 Annex 3 - Public Health Reasons/Administrative Guidelines, section 6-202.15 Outer Openings, Protected, dated 2022, indicated, . insects and rodents are vectors of disease-causing microorganisms which may be transmitted to humans by contamination of food and food-contact surfaces. The presence of insects and rodents is minimized by protecting outer openings to the food establishment .