

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Countryside		STREET ADDRESS, CITY, STATE, ZIP CODE 7700 US Highway 158 Stokesdale, NC 27357	

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** 50112</p> <p>Based on observation, record review, staff, Responsible Party (RP) and Nurse Practitioner (NP) interviews, the facility failed to prevent injury to a resident who sustained a laceration to his head when a corner shelf fell from the wall. This was for 1 of 2 residents reviewed for accidents. (Resident #55)</p> <p>The findings: Included:</p> <p>Resident #55 was admitted to the facility on [DATE] with diagnosis that included hemiparesis following cerebral infarction affecting right dominant side, unspecified dementia, dysphagia.</p> <p>Review of Resident #55 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was severely cognitively impaired and was dependent on staff for Activities of Daily Living (ADL's.)</p> <p>Review of incident report completed by Nurse#1 dated 8/31/23 revealed nurse aide (NA)#1 and NA#2 were getting Resident#55 ready to perform care when a corner overhead shelf fell landing on the bed and right side of the residents' forehead/scalp. The report further revealed Resident #55 sustained a laceration above his right forehead. The wound measured 2(cm) centimeters by .02 is width to the top of the resident forehead. The laceration had a very small amount of bleeding, was cleansed, and steri- strips were applied. The report indicated Resident #55 remained at baseline for his neurological status and he was unable to voice pain due to his cognition during the assessment. The RP and Nurse practitioner (NP), Director of Nursing (DON) and Administrator were notified. Resident #55's overall status was monitored.</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>Review of facility summary of incident dated 8/31/23 revealed 2 NA's (NA#1 and NA#2) were preparing to perform morning care on Resident #55 when an overhead corner shelf fell from the wall and landed on the bed and hit Resident #55 in the frontal section of the forehead. One NA stayed with Resident #55 while the other went to retrieve a nurse. The nurse immediately entered the room to assist and ensure the resident was safe. The summary further revealed the DON and the facility Administrator were summoned to the room. Upon arrival the Administrator assisted with the removal of the shelving unit. The Administrator spoke with the aids about what happened. Next, the Administrator called for the Maintenance Director to come to the room to see if a conclusion could be made as to how or why the shelf fell . A definitive answer could not be made regarding how or why the shelf fell , and as a result the Administrator requested that all corner shelves be removed from residents' rooms to prevent further accidents and or injury.</p> <p>Review of Nurses Progress Note dated 8/31/23 revealed around 9:40 am NAs were getting ready to perform care on Resident #55. The shelf over the head of bed (in corner to the right side of resident room) had fallen. The shelf (top part) was lying on resident with the top part of the shelf on Resident #55 forehead. The shelf was removed, and Resident #55 had a laceration to the top of his forehead which measured 2 cm in length and 0.2 in width. The laceration was cleansed with Saline and patted dry, a Steri-Strip applied until bleeding stopped and antibiotic ointment applied. An ice pack was applied the first 20 minutes after incident. The forehead had no swelling and no drainage. The resident was alert and mumbling the whole time. The NP was notified as was the RP. No new orders were given and the NP stated to monitor vital signs (VS). If VS were out of range, and/or Resident #55 had a change in condition, send him out to emergency room . However, if Resident #55 VS remained stable do not send him out. Neuro Checks were initiated at 9:45 am and recorded onto a Neuro work sheet. Maintenance removed the shelf from Resident #55's room. Written by Nurse # 1.</p> <p>Review of Medical Record 04/17/24 revealed Resident #55 revealed he was not on anticoagulant.</p> <p>Review of Provider Progress Note dated 9/14/23 stated there were no new complaints. Resident #55 had recovered from the laceration. The assessment further stated his 2cm laceration on his forehead had well approximated edges and no surrounding erythema. Written by NP # 1.</p> <p>Observation of Resident #55 room on 4/17/24 at 9:30 am revealed resident room did not contain any overhead shelves.</p> <p>Interview with NA #1 on 4/17/24 at 10:00 am revealed the was in the room with Resident #55 preparing him for a shower on 8/31/23 and was awaiting assistance from NA #2 when the incident occurred. A corner shelf fell from the right corner of the room falling onto the bed and Resident #55. She stated the bed took most of the impact of the shelf falling, but it did hit Resident#55 on the top of his head. NA was unaware of what caused the shelf to fall off the wall. While NA #2 stayed with Resident #55. NA #1 went to get Nurse #1.</p> <p>NA #2 was interviewed on 4/17/24 at 10:10 am. She was assisting NA #1 with Resident #55 preparing to transfer Resident #55 for bathing. As she entered the room the shelf came off the wall barely catching the top of Resident #55's head. NA #2 further stated that NA #1 left the room to get the nurse, and notify the DON, the Administrator. Nurse #1came into the room and did an assessment.</p> <p>Multiple attempts were made to reach Nurse# 1 by phone. A message was left with no return phone call.</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>An interview with the NP was conducted on 4/17/24 at 10:30 am. The NP declined to answer questions regarding the event as she was longer responsible for residents in the facility. She further stated that the event happened so long ago she was fearful of providing inaccurate information.</p> <p>An interview with the Director of Maintenance on 4/17/24 at 11:00 am revealed she recalled being summoned to Resident #55's room on 8/31/23 to determine how or why the shelf fell . She stated that no root cause could be identified and as a result, the Administrator requested that all corner shelves be removed from residents' rooms. The Maintenance Director stated no loose screws and no missing dry wall were observed.</p> <p>Resident #55's RP was interviewed on 4/17/23 at 1:30 pm. She stated she was notified by Nurse # 1 Resident #55 had sustained a laceration to the forehead after a shelf fell from the wall. She further stated by the time she arrived to the facility all the corner shelves had been removed from all resident rooms. The RP was unaware of how the shelf had fallen from the wall. Resident #55 did not have a scar and in her opinion did not suffer any ill effects from the incident.</p> <p>An interview was conducted with the DON on 4/17/23 at 2:15 pm. She could not recall specifics of how she learned of the event, but recalled going to the room where the nurse was conducting a head-to-toe assessment of Resident #55. She stated the resident had a small laceration on the top of his forehead near the scalp. The DON continued by stating that she was unsure if a root cause was determined for the shelf falling, but it was decided that removing all corner shelves would prevent potential harm. The RP and NP were notified, and the resident was not sent to the hospital for further evaluation.</p> <p>The Administrator was interviewed on 4/17/23 at 3:15 pm. She became aware of the incident regarding a shelf falling on Resident #55 during a daily morning meeting on 8/31/23 around 9:30 am. She stated that she and the DON reported to Resident #55 room and began to assist staff as needed. The Administrator stated that she assisted the nurse with removal of the shelving unit from the room. She further stated she began interviewing staff that witnessed the shelf fall and recalled summoning the Director of Maintenance to the room to assess the shelving. No root cause could be determined as to what or how the shelf came off the wall. To prevent injury to others the Administrator requested the removal of all corner shelves from resident rooms.</p> <p>The facility provided the following corrective action with a completion date of 09/4/23.</p> <p>The Administrator is the individual responsible for compliance with this action plan.</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Address how the facility will identify other residents having the potential to be affected by same deficient practice.</p> <p>After a review, Resident # 55 was affected by the shelf falling from the wall. The resident was immediately assisted and assessed. Resident NP and POA notified. The Maintenance Director immediately was notified to assess the corner shelf. This was completed on 8/31/23.</p> <p>After a thorough review, no other residents were affected at this time. To ensure all</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>Resident safety, all corner shelves were removed in every room due to unknown cause of the shelf falling. This was completed on 8/31/23.</p> <p>Due to unknown cause of the shelf falling, education was conducted to all staff by Administrator/Maintenance Director on reporting any equipment, outlets, furniture, shelving etc. that may be compromised and/or damaged to be reported immediately to maintenance and also put on maintenance order board.</p> <p>Address what measure will be put into place or systemic changes made to ensure what the deficient practice.</p> <p>All corner shelves removed on 8/31/23.</p> <p>Ad Hoc QA Meeting was held to review incident on /8/31/23.</p> <p>The QA committee consists of DON, Administrator, MDS Coordinator, Nursing Supervisor, Human Resources, Social Worker, Plant Operations Manager, and other department managers.</p> <p>Maintenance Director assed the corner shelf to understand the cause of it falling. No known cause was made therefore the facility removed all corner shelves.</p> <p>Due to unknown cause of the shelf falling, education was immediately started on 8/31/23-9/4/23 conducted to all staff by Administrator/Maintenance Director on reporting any equipment, outlets, furniture, shelving, etc. that may be compromised and or damaged to be reported immediately to maintenance and also put on maintenance order board.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.</p> <p>On 8/31/23, Administrator held an Ad hoc Quality Assurance Meeting.</p> <p>Due to unknown cause, Education started in every department to review on reporting any equipment, outlets, furniture, shelving etc. that may be compromised and or damaged to be reported immediately to maintenance and also put on order board.</p> <p>All corner shelves were removed on 8/31/23.</p> <p>Due to removing all corner shelves, no monitoring or performance needed.</p> <p>Corrective actions were implemented 8/31/23 to remove all corner shelves. All corner shelves were removed and completed 8/31/23. All education was conducted between 8/31/23-9/4/23. All corrective actions were completed on 9/4/23.</p> <p>On 4/18/2024 the facility's correction action plan was validated by the following:</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>The facility provided documentation to support their corrective action plan including education provided to the Maintenance Director, and every department. The Maintenance Director audited and removed all corner shelving units in all resident rooms on 8/31/23. Observations were conducted of all residents' rooms and revealed no corner shelving. QAPI meetings were discussed with the Administrator and meeting notes were reviewed. There have been no further incidents accidents of falling objects onto residents.</p> <p>The facility's date of 9/4/23 for the corrective action plan was validated on 4/18/24.</p>		