STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345390	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside	7700 US Highway 158 Stokesdale, NC 27357

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, return demonstration, record review and staff interviews, the facility failed to provide care in a safe manner when Resident #8 rolled out of bed with the bed raised to a high position hitting the floor during incontinence care. Resident #8 was transported to the Emergency Department and diagnosed with a mildly displaced fracture of the proximal metaphysis of the tibia, likely subacute (a break in the upper part of the shinbone [tibia] near the knee, where the bone is slightly out of alignment and has likely been healing for a few days to weeks). The facility also failed to provide care in a safe manner when Resident #3 was left alone with the bed in the highest position and the bed rail down. This deficient practice affected 2 of 4 residents reviewed for supervision to prevent accidents (Resident #8 and #3).The findings included: 1. Resident #8 was admitted to the facility on [DATE] with diagnoses that included neurocognitive disorder with Lewy bodies (a progressive brain disease caused by abnormal protein deposits called Lewy bodies), restlessness and history of agitation, right sided hemiparesis/hemiplegia (paralysis of one side/muscular weakness) status post cerebrovascular accident (CVA) (a stroke), cognitive impairment related to dementia, generalized weakness and debility, bowel and bladder incontinence, and decreased mobility and functional abilities. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed an interview could not be completed for Resident #8. There were no behaviors present and Resident #8 was dependent for all activities of daily living (ADL) care. The Resident was dependent in rolling left and right, and with sit to lying. He was dependent in transfers. Resident #8 was always incontinent in bowel and bladder. Resident #8 did not have any falls since admission/entry or reentry or the prior assessment. A review of Resident #8's care plan dated 5/29/26 revealed a focus problem that started 2/26/25 that required staff to assist with ADLs secondary to decrease in self-care and mobility secondary to hemiplegia/hemiparesis. Resident was noted to have an increase in staff support for his functional abilities. Interventions with a start date of 4/16/26 included extensive assistance times 1 staff for grooming, extensive assistance times 1 to 2 staff for dressing, extensive assistance of 2 staff with bathing and transfers related to use of a total mechanical lift.A review of Resident #8's care plan dated 5/29/26 revealed a focus problem of falls that started on 2/26/25 where resident was at risk for falls due to right hemiplegia/hemiparesis status post cerebrovascular accident (CVA), cognitive impairment related to dementia, bowel and bladder incontinence, decreased mobility and functional abilities. Resident #8 was dependent on staff assistance with transfers and mobility. Interventions with a start date of 4/16/26 included assess fall risk potential per facility protocol, bed in low position, and ensure brakes were locked for fall prevention measures.An incident report dated 5/25/26 at 3:53 AM written by Nurse #3 revealed Resident #8 was rolled off the bed onto the floor on 5/24/26 at 10:15 PM. Nurse #3 was notified by Nurse Aide (NA) #2 that Resident #8 rolled off the bed during care. Resident #8 experienced a witnessed fall in his room. Nurse #3 entered the room and observed Resident #8 lying on his right side on the floor alongside his bed. A skin assessment was completed by Nurse #3 which revealed Resident #8 with a contusion under his right eye, swelling and redness was noted to his right elbow and a skin tear to his mid right arm and top of his left hand. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no other apparent injuries noted. The on-call provider, resident's spouse, the Director of Nursing, and nurse supervisor were contacted. Resident #8 was transferred to the emergency room for further evaluation. Interventions following the fall included an update to Resident #8's plan of care for 2-person assist with bathing, turning, and repositioning as well as transfers. A Fall Assessment was also completed by Nurse #3 with the same information as stated above.The post fall assessment dated [DATE] indicated Resident #8 was nonverbal and there was no numerical pain level recorded.On 6/22/26 at 6:42 AM, Nurse #3 was interviewed and reported that she was on duty the night Resident #8 fell (5/24/26). Nurse #3 stated the resident did not talk, was total care, was incontinent of bowel and bladder and required a twoˆperson assist. According to Nurse #3, NA #2 was in the room with Resident #8 at the time of the fall. NA #2 had informed her that the resident had a skin tear on his upper left arm. As she was preparing to call the resident's spouse regarding the skin tear, she heard NA #2 yelling that Resident #8 had fallen. She went to the room and found the resident on the floor. Nurse #3 stated she assessed the resident, then called 911 and notified the resident's spouse, the provider, the Director of Nursing (DON), and the supervisor. Nurse #3 stated Resident #8 fell during personal care, and to her knowledge, he had never had a fall before during the time she worked at the facility. The Nurse stated Resident #8 had a soft leg brace on his left leg and interventions put into place since the fall included checking the resident's left leg every shift and elevating his leg on a pillow.A telephone interview with Nurse Aide (NA) #2 was conducted on 6/23/26 at 9:12 AM. NA #2 reported that Resident #8 was dependent on staff for all personal care. He stated that he was putting Resident #8 to bed and had begun providing incontinent care. While turning the resident onto his left side, he attempted to remove either the incontinent pad or the total mechanical lift sheet from underneath the resident but could not recall which item he pulled. Resident #8 was already positioned at the head of the bed. NA #2 explained that while the resident was on his left side, the resident's legs extended over the edge of the bed, and gravity caused the resident's body to slide off the bed and onto the floor. He noted that the bed rail was raised on the side the resident was facing. NA #2 stated he was standing next to the wall and rolled the resident away from him, onto the resident's left side. The NA stated due to his tall height, the resident's bed was raised to a higher position at the time. According to NA #2, due to the resident's stature, the side rails reached the resident's upper chest area. He described that Resident #8's feet went off the bed first, followed by the rest of his body, which gravity then pulled downward. When the resident reached the floor, his legs made contact first, beginning with the left leg and he rolled off the bed onto his left shoulder before ending up on his right side. NA #2 stated the resident's body grazed the edge of the nightstand, and the resident's face also grazed it, causing the bruise or small cut observed on the right side of his face. NA #2 reported that immediately after the resident reached the floor, he notified Nurse #3. He stated he had been positioned right beside the resident the entire time and had not walked away prior to the fall. After the incident, he discussed what happened with Nurse #3. The following day, he spoke with Nurse #4 (the nurse supervisor), and received guidance on safe rolling techniques, the need for two-person assistance with this resident, avoiding rolling the resident away from his body, ensuring the resident was properly positioned up in bed, and maintaining correct body posture during care. NA #2 stated when the incident occurred, this was only the second weekend he had worked with Resident #8 as he had only been employed with the facility a month and a half.On 6/24/26 at 4:10 PM, NA #2 provided a demonstration of how Resident #8 fell. NA #2 stated he used the resident's incontinence pad to turn the resident onto his left side. He demonstrated pulling the pad as he turned the resident. During the demonstration, NA #2 explained that Resident #8's foot jerked. NA #2 stated that Resident #8's foot went off the side of the bed, and then the resident slid off the bed and onto the floor.Review of the hospital emergency department (ED) report dated 5/24/26 indicated Resident #8 arrived following a fall at the facility that occurred during a transfer back into bed. The ED report indicated Patient is holding his left leg in a flexed position and exhibits pain with movement. Radiology was completed. The Final diagnoses: Fall at the nursing home. Other closed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fracture of proximal end of the left tibia (a broken left shinbone [tibia] near the knee joint). Resident #8 was discharged back to the facility in good condition on 5/25/26. The discharge order included oxycodone (pain medication) 5 milligrams (MG) immediate release tablet every 6 hours as needed (PRN). Radiology results revealed a left knee x-ray that showed a mildly displaced fracture of the proximal metaphysis of the tibia, likely subacute (a break in the upper part of the shinbone [tibia] near the knee, where the bone is slightly out of alignment and has likely been healing for a few days to weeks). The treatment plan for the fracture included pain medication and the application of a splint. Resident #8 was referred to an orthopedic surgeon to discuss surgical versus nonsurgical options.Review of a nursing progress note written by Nurse #4 dated 5/25/26 at 12:43 PM indicated Resident #8 returned to the facility from the emergency department via stretcher at 9:43 AM.An interview with Nurse #4 was held on 6/22/26 at 10:44 AM. She reported that Resident #8 was a total mechanical lift resident. Nurse #4 stated Nurse #3 called her the night Resident #8 fell. Nurse #4 stated she was told by Nurse #3 that NA #2 informed Nurse #3 when he went to roll Resident #8 for incontinent care, he rolled the resident towards the door, and the resident fell off the bed. Nurse #4 stated she wasn't sure if the resident's bedrail was up. She stated she spoke to all NAs and changed Resident #8 to a 2-person assist with all care. Nurse #4 stated Resident #8 had no other falls since her employment at the facility for 5 years, and that the 5/24/26 fall had been the only fall Resident #8 had. Nurse #4 stated staff were educated on fall prevention after the resident's fall. Staff are also educated on falls/prevention during their skills fair every October/November.On 6/24/26 at 2:44 PM, an interview was held with the Director of Nursing (DON). The DON stated NA #2 pulled the sheet to assist with turning Resident #8 and the resident rolled out of bed. The DON stated she did a one-to-one training with NA #2 following the incident. She re-educated NA #2 that residents were never rolled away from you unless there was another person assisting. She stated the facility implemented a 2-person assist with all care for Resident #8, and his care plan had been updated related to that fall.During a follow-up interview with the DON on 6/25/26 at 8:59 AM, she stated Resident #8 was not a 2-person assist prior to the fall as he never needed to be one for personal care, but he was a 2-person assist only for transfers. The DON stated no one had voiced any concerns regarding needing additional assistance during resident's personal care.An interview with the Administrator was held on 6/24/26 at 2:44 PM. The Administrator stated staff were educated about fall prevention during orientation and every year at their annual skills fair. Education on fall prevention included putting beds in the lowest position, fall mats down, and call bell within reach.During a follow-up interview with the Administrator on 6/25/26 at 8:59 AM, she reported Resident #8 had a foam topper on his bed the night he fell out of bed. However, the foam topper was no longer on his bed. The Administrator stated Resident #8's POA requested the topper for resident's comfort. The Administrator stated education was previously provided to the POA that [mattress] overlays were not recommended due to resident safety. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and debility, cardiorespiratory conditions.A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed an interview could not be conducted for Resident #3. There were no behaviors present and Resident #3 was dependent in self-care and mobility. She was dependent in rolling left and right, and with sit to lying. Resident #3 did not have any falls since admission/entry or reentry or the prior assessment.Review of Resident #3's Fall Risk Assessment Tool dated 3/24/26 indicated resident had not falls within the previous 6 months. Resident #3 required assistance or supervision for mobility, transfer, or ambulation.A review of Resident #3's care plan dated 5/29/26 revealed resident was at risk for falls related to medication side effects, impaired mobility, limited mobility related to hand contractures, cognitive impairment, and dependence on staff assistance for all her activities of daily living (ADLs). Interventions included keeping bed in low position with brakes locked and monitor resident for position in bed. Ideal position for resident would be in the center of the bed to assist with fall prevention measures.An observation and interview were conducted on 6/22/26 at 6:13 AM with Nurse Aide (NA) #1. She was performing (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incontinent care on Resident #3. The NA needed an additional washcloth and stepped outside of the room (linen cart was right outside of resident's door). Resident #3 was observed left unattended on her left side, bed in the highest position, and the side rail that was opposite from how the resident was turned was down. When NA #1 returned to the room, she went to the bathroom to wet the washcloth before returning to the bedside. During the continuous observation and interview with NA #1, she stated she normally would move the rail back up and the bed down when leaving the resident's bedside. During the interview, NA #1 did not state why she left the bed up and the side rail down. Interview with the Director of Nursing (DON) on 6/22/26 at 8:23 AM revealed prior to leaving a resident's bedside if a Nurse Aide (NA) had to obtain additional linen, the NA was expected to ensure the resident was positioned in a safe position with the bed in the lowest position, and bed rails raised.On 6/24/26 at 1:54 PM, an interview with the Administrator revealed staff were expected to make sure residents were safe, and that residents were placed onto their back and the bed lowered before stepping away from the bed. The Administrator stated NA #3 would receive one on one training regarding resident safety.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to remove loose and unsecured pills of various shapes, sizes and colors in 2 of 2 medication carts (Front Hall Medication Cart #1 and Back Hall Medication Cart #1) reviewed for medication storage.The findings included:a. An observation was conducted on 6/23/26 at 3:10 pm of Front Hall Medication Cart #1 in the presence of Nurse #1. The observation revealed the following medications were stored in the medication cart:-Two loose small round white tablets with the marking EP 116 found in the second drawer of the medication cart,-One loose medium round white tablet with the marking 502 found in the second drawer of the medication cart,-Two loose small oblong white tablets with marking A found in the second drawer of the medication cart,-One loose small oblong orange capsule found in the second drawer of the medication cart,-One loose small oblong white tablet with the marking 152 found in the fourth drawer of the medication cart,-One loose large oblong orange tablet with marking 50/50 found in the fourth drawer of the medication cart.An interview was conducted on 6/23/26 at 3:10 pm with Nurse #1. When asked, Nurse #1 confirmed that loose tablets of medication were observed on Front Hall Medication Cart #1. Nurse #1 was unable to explain why medications were stored without minimum information required, including the name of the resident or prescribing information. Nurse #1 was unable to provide any additional information related to facility process for checking medication carts or pharmacy audits of the medication carts. b. An observation was conducted on 6/23/26 at 3:24 pm of Back Hall Medication Cart #1 in the presence of Nurse #2. The observation revealed the following medications were stored on the medication cart: -Two loose small round white tablets found in the first drawer of the medication cart,-One loose small oblong white tablet with the marking A10 found in the first drawer of the medication cart,-Two loose medium round white tablets found in the third drawer of the medication cart,-Two loose small round white tablets found in the third drawer of the medication cart,-One loose small round orange tablet found in the third drawer of the medication cart.An interview was conducted on 6/23/26 at 3:24 pm with Nurse #2. When asked, Nurse #2 confirmed that loose tablets of medication were observed on Back Hall Medication Cart #1. Nurse #2 indicated that the pharmacy was using new packaging that was not as durable as the previous packaging. Nurse #2 also stated the carts were audited by the pharmacy monthly. She further indicated that the lack of durability of the new packaging could be a contributing factor to the loose medications. Nurse #2 could not give a definite explanation to why medications were stored without the minimum information required, including the name of the resident or prescribing information.An interview was conducted on 6/23/26 at 3:53 pm with the Director of Nursing (DON) to discuss the concerns that were identified during the medication storage observation. The DON could not give an explanation to why loose tablets were observed on the Front Hall Medication Cart #1 or the Back Hall Medication Cart #1. The DON stated there was no system in place by the facility to audit the medication carts, but the carts were audited monthly by the pharmacy. She indicated she would expect the staff to dispose of loose medication according to policy. The DON stated she was not aware of the issue concerning the durability of the new pill packages being distributed by the pharmacy. An interview was conducted on 6/23/26 at 4:39 pm with the Administrator to discuss the concerns that were identified during the medication storage observation. The Administrator could not give an explanation to why loose tablets were observed on the Front Hall Medication Cart #1 or the Back Hall Medication Cart #1. The Administrator indicated she would expect staff to follow the policy and procedure for storing and disposing of medication. She further indicated that she was made aware of staff concerns related to the durability of the new pill packages being distributed by the pharmacy the day of the observation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and staff interviews, the facility failed to follow their Infection Control policies and procedures for hand hygiene when Nurse Aide (NA) #1 failed to remove her gloves and sanitize her hands before opening Resident #3's room door to obtain additional washcloths during incontinent care, and when Nurse #3 failed to sanitize her hands after medication administration and contact with Resident #19. The deficient practice occurred for 2 of 7 staff observed for infection control practices (NA #1 and Nurse #3).The findings included:Review of the facility's Standard Precautions policy and procedure last revised on 10/2025 revealed the following:Hand hygiene:Hand hygiene refers to hand washing with soap or the use of alcohol-based hand rub, which does not require access to water.Hand hygiene is performed with alcohol-based hand rub or soap and water:before and after contact with the resident,before performing an aseptic task,before moving from work on a soiled body site to a clean body site on the same resident,after contact with items in the resident's room, andafter removing gloves.Gloves:Gloves are removed promptly after use, before touching non-contaminated items and environmental services, and before going to another resident.After gloves are removed, hands are washed immediately to avoid transfer of microorganisms to other residents or environments. 1. An observation and interview were conducted on 6/22/26 at 6:13 AM with Nurse Aide (NA) #1. NA #1 donned her gloves as she was about to perform incontinent care on Resident #3. NA #1 removed Resident #3's brief that contained urine and cleaned her buttocks with a washcloth. NA #1 stated that she needed an additional washcloth to continue providing incontinent care. Without removing her gloves, NA #1 touched the door handle with her soiled gloves and stepped outside of the room (linen cart was right outside of resident's door) to obtain an additional washcloth. When NA #1 returned to the room, she still had on the same pair of gloves. She proceeded to the bathroom to wet the washcloth. NA #1 returned to Resident #3's bedside and continued providing incontinent care with washing the resident's buttocks and donning a new brief. Continuous observation of NA #1 revealed she did not remove the gloves she used to remove a soiled brief prior to touching the door handle and exiting the room to obtain clean bath linen. During the continuous observation and interview with NA #1, she stated the gloves should have been removed and hand hygiene performed prior to opening the door and stepping outside the room to obtain additional washcloths. During the interview, NA #1 did not state why she did not perform hand hygiene. Interview conducted with the Infection Control Preventionist (ICP) on 6/24/26 at 8:44 AM revealed staff have been educated to never have gloves on in the hallway. If staff need to leave a resident's room, they should remove their gloves, sanitize their hands, then when they re-enter, they should sanitize their hands again and don new clean gloves. The ICP stated she would provide re-education to NA #1 regarding hand hygiene.Interview with the Director of Nursing (DON) on 6/22/26 at 8:23 AM revealed staff were to remove gloves and sanitize their hands after resident contact. The DON stated that staff were expected to perform hand hygiene when entering and leaving a resident's room. 2. On 6/22/26 at 6:37 AM, an observation and interview with Nurse #3 revealed Nurse #3 had entered Resident #19's room to administer her medication and obtain an oxygen saturation reading (measures the percentage of red blood cells carrying oxygen in your bloodstream) using a pulse oximeter (a small, noninvasive device that clips onto your finger and uses light absorption to estimate your oxygen saturation). Nurse #3 did not have on gloves. The medications were administered and a pulse oximeter was used. After Nurse #3 obtained the reading she placed the pulse oximeter into her pocket, exited the resident's room, and proceeded to the medication cart without sanitizing or washing her hands. As Nurse #3 approached the medication cart, she began typing on her computer. Nurse #3 did not sanitize her hands nor clean the pulse oximeter which remained in Nurse #3's pocket. During the continuous observation and interview with Nurse #3, she indicated hand hygiene should have been completed after each resident during medication administration pass. When asked about hand hygiene after administering medication and obtaining an oxygen saturation for Resident #19, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #3 stated she did not perform hand hygiene because she was not going to another resident. Interview conducted with the Infection Control Preventionist (ICP) on 6/24/26 at 8:44 AM revealed staff were educated to perform hand hygiene between each resident contact during medication pass or if their hands become soiled. Staff were supposed to clean equipment that was used on residents with Sani wipes after each use. Equipment should be cleaned between each resident. The ICP stated she would provide re-education to Nurse #3 regarding hand hygiene and cleaning equipment.Interview with the Director of Nursing (DON) on 6/22/26 at 8:23 AM revealed Nurse #3 was to use hand sanitizer between residents during medication pass and after each resident contact. Staff were expected to perform hand hygiene when entering and leaving a resident's room. Devices used during resident care, such as a pulse oximeter, should be cleaned after each use.