

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/08/2024
NAME OF PROVIDER OR SUPPLIER Countryside Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 East 154th Street Dolton, IL 60419	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observation, interview, and record review, the facility failed to keep a resident (R3) free from abuse by another resident (R5) and failed to keep a resident (R5) free from verbal abuse by staff. These failures applied to two (R3, R5) of five residents reviewed for abuse.</p> <p>Findings include:</p> <p>1. R3 is a [AGE] year-old male with a diagnoses history of Vision Loss in Right Eye, History of Falling, Abnormal Posture, Unsteadiness on Feet, Prostate Cancer, Hypertensive Heart Disease, and Type 2 Diabetes Mellitus who was admitted to the facility 05/20/2024.</p> <p>R5 is a [AGE] year-old male with a diagnoses history of Multiple Fractures, Unspecified Psychosis, Psychoactive Substance Use, and Cerebral Infarction who was admitted to the facility 06/26/2023.</p> <p>On 08/05/2024 from 11:55 AM - 12:03 PM Observed R3 sitting in the nursing office with a large bump on the top of his head. Observed V4 (Assistant Director of Nursing) placing ice on top of R3's bump. V4 stated R3's bump resulted from the physical altercation he was in with R5 and he was being sent to the hospital for evaluation.</p> <p>On 08/05/2024 at 12:36 PM From the facility's video recordings observed V10 (Certified Nursing Assistant) alone in the dining area intervening in an altercation between R3 and R5; Observed R5 leave the dining area after the altercation; Observed R5 return to the dining room while V8 (Certified Nursing Assistant) was sitting alone in a doorway in between two dining rooms monitoring multiple residents with her back to R3 and R5; observed R5 picking up a chair while sitting in his wheelchair; observed V8 walk over and redirect R5 to put the chair down then return to the chair in the doorway in between dining rooms, observed moments later R5 grabbed the back of R3's wheelchair wheel and R3 responded by repeatedly attacking R5 with a cane; Observed V8 with a delay in intervening in the altercation after it began then struggle to restrain R3 and R5; Observed V7 (Certified Nursing Assistant) then intervene moments after V8 to assist her in stopping the altercation; observed V7 restrain R5 after he repeatedly punched R3 in the head; observed V5 (MDS Coordinator I) respond moments after V7 began restraining R5 from punching R3; observed multiple staff then enter the dining room moments after V5 to assist.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R3's progress note dated 08/05/2024 at 11:45 AM documents he was involved in an altercation with another resident and sustained a bump on the top of his head. Physician called and updated stated to send resident out for acute evaluation.</p> <p>On 08/05/2024 at 1:11 PM V8 (Certified Nursing Assistant) stated she has worked at the facility for four days. V8 stated she did three days of orientation last week and started working at the facility today. V8 stated she was assigned to sit in the dining area to monitor the residents from 11:30 AM - 12:00 PM and she was the only staff present during that time. V8 stated there were more than 10 residents between the two dining rooms. V8 stated she doesn't know the residents because it's her first day. V8 stated she didn't hear any arguing before the fighting began, she just heard the noise of something hitting the table and when she turned around, she saw R5 and R3 fighting each other. V8 stated if she hears residents arguing she is trained to take one to the nurses station and report. V8 stated she has not yet received training on what to do when she witnesses residents in an altercation or fighting. V8 stated she will receive a class training tomorrow on what to do when residents are fighting. V8 stated she was not given any information about any of the residents having a history of aggressive behavior.</p> <p>On 08/05/2024 at 2:37 PM V10 (Certified Nursing Assistant) stated she has worked at the facility for two months. V10 stated when she was in the dining room monitoring the residents from 11:14 - 11:30 in both dining rooms, R5 was arguing with another resident, then he and R3 began arguing. V10 stated she then turned around and redirected them and asked R5 to calm down. V10 stated R5 then moved away back to his table. V10 stated she then turned around and R5 approached R3 again and they were both standing in each other's face as if they were going to fight so she got up and intervened. V10 stated she redirected both residents, helped R3 to his chair and pushed him towards the table and R5 left the dining area. V10 stated V8 (Certified Nursing Assistant) relieved her in the dining area at 11:30 AM. V10 stated she was trained to deescalate residents when arguing by separating and redirecting them. V10 stated if residents get involved in a physical altercation, she was trained to separate them and make sure they are both safe, then report to the nurse or supervisor and the administrator.</p> <p>On 08/06/2024 at 12:45 PM R3 stated R5 bullies people. R3 stated R5 hit him in his head and pointed out the bump on his head for surveyor.</p> <p>On 08/06/2024 2:12 PM V1 (Administrator) stated it would be better for more than one staff to be present and respond during physical altercations among residents. V1 stated generally social services would assess the residents after a verbal altercation and provide interventions as needed. V1 stated V10 (Certified Nursing Assistant) reported she broke up a verbal altercation between R5 and R3 prior to their physical altercation and R5 left the dining room. V1 stated V10 should have reported the verbal altercation to social services as soon as possible. V1 stated staff should respond and intervene immediately when residents are engaged in a physical altercation. V1 stated some form of communication should have been had with V8 about the verbal altercation between R3 and R5 but she doesn't believe V10 had a chance to. V1 stated CPI (Crisis Prevention Intervention) training is usually done during orientation.</p> <p>On 08/06/2024 at 2:54 PM V14 (Human Resource Director) stated V8 (Certified Nursing Assistant) was hired 07/25/2024 and had orientation from 07/30/2024 - 08/01/2024. V14 stated V8 was supposed to have CPI (Crisis Prevention Intervention) training on Tuesday 07/30/2024 but the director over the training V15 (Social Services Worker) who is certified in CPI training was on vacation. V14 stated V8 is scheduled to have CPI training on Tuesday 08/13/2024.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. On 08/05/2024 at 11:44 AM Observed V7 (Certified Nursing Assistant) swearing at R5 while restraining him by holding his arm after a physical altercation with R3. V7 stated she has worked for the facility for six years. V7 stated she heard a commotion coming from the dining area while outside monitoring another resident for a smoke break and responded to the dining area to assist another staff in breaking up a fight between R5 and R3. V7 stated she observed R5 hitting R3 in his wheelchair and attempted to intervene. V7 confirmed the surveyors observation of her stating to R5 you must be out of your mother F'n mind. V7 stated this was inappropriate because it is considered abusive.</p> <p>The facility's Policy on Techniques in De-Escalating Behavior received/reviewed on 08/06/2024 states:</p> <p>Your behavior is the ONLY thing you can Control when providing intervention.</p> <p>Please be reminded that, as professional health care personnel, we assume the role of providing supervision on behalf of those for whom we provide care, each day.</p> <p>Because the health and safety of all residents, staff and visitors are a Priority, we provide CPI (Crisis Prevention Intervention) training to all personnel as a strategy to de-escalate behaviors, as may become necessary in a manner designed to provide safe interventions.</p> <p>Do not try to exert dominance or influence. Speak courteously and calmly.</p> <p>Observe - Separate Conflicting Parties.</p> <p>Do not approach incidents of behavior alone by ensuring to do so with at least one other staff person.</p> <p>Recognize the individual as a person deserving of respect and understanding.</p> <p>Speak calmly with assurance the situation will be resolved.</p> <p>Continue to provide any supporting supervision that may be needed.</p> <p>Be certain to make a verbal report.</p> <p>The facility's Abuse Prevention Program Facility Policy and Procedure received/reviewed on 08/06/2024 states:</p> <p>Abuse is defined as the willful infliction of injury with resulting physical harm, pain, or mental anguish. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm or mental anguish. It includes verbal abuse and physical abuse. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>Physical abuse is the infliction of injury that occurs other than by accidental means and requires medical attention. Examples include hitting, slapping, punching, and handling roughly.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Verbal abuse is the use of oral, written, or gestured language/communication that includes disparaging and derogatory terms to residents within their hearing/seeing distance. Examples include swearing, yelling, threatening harm, trying to frighten the resident, etc.</p> <p>During orientation of employees, the facility will cover at least the following topics: How to assess, prevent and manage aggressive, violent and/or catastrophic reactions of residents in a way that protects both residents and staff.</p> <p>Employees are required to report any incident of potential abuse they observe to the administrator immediately or to an immediate supervisor who must then immediately report it to the administrator.</p> <p>Incidents will be reviewed, investigated and documented, whether or not abuse occurred.</p> <p>Residents who allegedly abused another resident will be removed from contact with other residents during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on interview and record review, the facility failed to follow their policy and procedures for identifying and reporting an injury of unknown origin to the State agency. This failure applied to one (R3) of five residents reviewed for resident injuries.</p> <p>Findings include:</p> <p>R3 is a [AGE] year-old male with a diagnoses history of Vision Loss in Right Eye, History of Falling, Abnormal Posture, Unsteadiness on Feet, Prostate Cancer, Hypertensive Heart Disease, and Type 2 Diabetes Mellitus who was admitted to the facility 05/20/2024.</p> <p>Grievance form dated 05/22/2024 documents V12 (Family Member) reported another family member observed R3 earlier that day with a swollen left eye when visiting, and asked if he had a fall or was hit by someone, Investigation revealed he had a swollen left eye, he was unsure of what happened and his roommate reported he had a fall, R3 was assessed by nursing and was sent to the emergency room for an evaluation and returned. The grievance form did include any record that R3's roommate reported witnessing or observing R3 fall.</p> <p>R3's progress note dated 05/22/2024 at 12:52 PM documents R3 was sent to the hospital related to a possible unwitnessed fall.</p> <p>On 08/06/2024 at 11:52 AM V3 (Director of Nursing) stated the report from V12 (Family Member) documented on a grievance form 05/22/2024 should have been reported to the state agency based on the information in the report.</p> <p>Review of the facility's reportable incidents from May - August 2024 did not include a report regarding R3's swollen eye.</p> <p>The facility's Abuse Prevention Program Facility Policy and Procedure received/reviewed on 08/06/2024 states:</p> <p>For resident injuries not involving an allegation of abuse, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident and The injury is suspicious because of the extent of the injury of the location of the injury (for example the injury is located in an area not generally vulnerable to trauma).</p> <p>If the injury is classified as an injury of unknown source, the procedures and time frames for reporting and investigating abuse will be followed.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When an allegation of abuse has occurred, the Department of Public Health's regional office shall be informed by telephone or fax. Public Health shall be informed that an occurrence of potential abuse has been reported and is being investigated.</p> <p>Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.</p>