STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. Building B. Wing	08/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Nursing & Rehab Ctr	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34072 Based on observations, interviews, and record reviews, the facility failed to prevent an incident of resident to resident abuse. This affected two of three residents (R1, R2) reviewed for abuse. This failure resulted in R1, with a history of aggressive behavior, exhibiting verbal aggression towards R2 which escalated to physical aggression with R1 swinging his arms at R2 and pushing R2 onto the floor. Findings include: On 8/14/24 at 10:00 AM, this surveyor observed the men's shower room located 8 feet from the nurses' station. The shower stalls are located immediately to the left of the door. On 8/14/24 at 1:30 PM, V4 LPN (licensed practical nurse) stated that V4 was at the nurses' station at time of incident on 6/20/24. V4 stated that R2 kept opening shower room door while R1 was taking a shower. V4 stated that R1 asked R2 to shut the door. V4 stated that attempts to re-direct R2 were unsuccessful. V4 stated that R2 then held the shower room door open. V4 stated that R1 asked R2 again to shut door, then R1 came out of shower and tackled R2, both residents fell to floor. On 8/14/24 at 1:35 PM, V3 LPN stated that V3 was at nurses' station with other nurse, V4, at the time of the incident. V3 stated that V3 heard yelling from the men's shower room. V3 stated that V3 observed R2 outside of shower room and R1 telling R2 to close the door. V3 stated that then V3 observed R1 lunge at R2 and both residents fell on to the floor. V3 stated that V3 heard R1 tell R2 a few times to close the door. V3 stated that V3 did not hear R2 respond to R1. On 8/15/24 at 11:05 AM, V6 CNA (certified nurse aide) stated V6 was supervising R1 taking a shower on 6/20/24. V6 stated that R2 kept coming in and out of shower room and V6 attempted to re-direct R2. V6 stated that R1 was telling R2 to close the door. V6 stated that V6 called out to the nurse to call a counselor to assist him. V6 stated that V6 was standing in the shower room when R1 got out of the shower and went out the door and hit R2. V6 stated that R1 swung at R2 and pushed him down, R1 also fell with R2. V6 stated that V6 does not recall R2 saying anything to R1 throughout this incident. (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
	145798	A. Building B. Wing	08/15/2024

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/24 at 1:10 PM, V8 PRSC (psychiatric rehabilitation services coordinator) stated that V8 assessed R1 when he was first admitted to this facility in April 2024. V8 stated that R1 was always agitated. V8 stated that R1 would become more agitated if he felt he was being crowded in. V8 stated on 6/20/24, R1 was taking a shower and R2 kept opening the shower room door. V8 stated that she arrived at facility after the incident occurred and R1 and R2 were already separated. V8 stated that R1 was transported to the hospital after this incident due to aggression. V8 stated that she interviewed R1 upon R1's return from the hospital. V8 stated that R1 informed her that he kept telling R2 to shut the shower room door. R1 was becoming more agitated because R2 would not shut the door. R1 lunged at R2 and both fell to floor. V7 CNA was working on 6/20/24 when the incident occured. Attempts to interview V7 CNA during this survey were unsuccessful. R1 was admitted to this facility on 4/10/24 with diagnoses including, but not limited to, schizophrenia, violent behavior, paranoid personality disorder, and bipolar disorder. R1's pre-admission hospital record, dated 4/3/24-4/10/24, notes R1's chief complaint was homicidal ideations, aggression, and paranoia. R1's verbal behaviors care plan, initiated 5/29/24, notes R1 displays verbal behavioral symptoms directed toward peers and staff as evidenced by: using foul language and making threats of harm when refusing re-direction. Interventions implemented on 5/29/24 include staff will attempt to anticipate R1's needs in order to decrease verbal behavioral symptoms; staff will separate R1 from others as needed; staff will attempt to safely re-direct and intervene during periods of increased agitation; staff will refer to psychologist/psychiatrist for behavior management as needed; and social services and other staff will assess for aggression. R1's physical behaviors care plan, initiated 5/29/24, notes R1 displays physical behavioral symptoms directed toward others and staff. R1 is aggressive and lacks control to take re-direction. Interventions implemented on 5/29/24 include staff will attempt to anticipate R1's needs in order to decrease physical behavioral symptoms; staff will separate R1 from others as needed; staff will attempt to safely re-direct and intervene during periods of increased agitation; refer to psychologist/psychiatrist for behavior management as needed; and social services and other staff will assess for aggression. The facility's abuse prevention policy, dated February 2017, notes the facility is committed to protecting its residents from abuse by anyone including, but not limited to, other residents. Abuse means any physical injury upon a resident other than by accidental means.