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Form Approved OMB
No. 0938-0391

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	10/10/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to notify resident's representative of a change in condition. This failure applied to one (R1) of five residents reviewed for change in condition. Findings include: R1 is a [AGE] year-old male admitted to the facility on [DATE] with past medical history of Rheumatoid arthritis, Hypertensive heart disease, dysphasia oral phase, coagulation defect, epistaxis, gastro -esophageal reflux disease with esophagitis without bleeding, dependent on supplemental oxygen, dyspnea, difficulty walking, etc. Progress note written by V13 (Licensed Practical Nurse / LPN) dated 08/10/2024 03:02 PM, reads: code blue was called on resident for being unresponsive, staff started chest compressions and continued until emergency services arrived. Resident was transported to a local hospital around 9:35AM, MD and nursing administration notified, unable to reach family. Surveyor review of medical records did not include any documentation of any endorsement to the next shift to follow up with family or any documentation that another attempt was made to reach the family by the facility. R1 was also sent to the hospital on 7/5/2024 for complaint of chest pain, returned the same day and there was no documentation that family was notified of the transfer or return. 10/7/2024 at 2:27PM, V11 (Family Member) said that she came to the facility to visit resident on Friday, 8/9/2024 and (R1) was not feeling well, he was having breathing problems and staff were talking about giving him a breathing treatment. On Sunday, 8/11/2024 at 6:07PM, V11 received a call from the hospital telling her that R1 had a heart attack on Saturday, his heart was stopped for 25 minutes and by the time he got to the hospital, he was brain dead due to lack of oxygen to the brain. V11 never received any call from the facility and when she tried to call them, she could not reach anyone. V11 added that R1 was in the hospital sometime in July and it was the hospital that notified her. V11 added that the facility does not call her for anything. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/7/2024 at 4:28PM, V3 (Director of Nursing /DON) said that she does not think she was notified when R1 coded at the facility. She became aware of it when she came back to work on that Monday because the incident happened on a Saturday. V3 stated that she was told that staff found R1 unresponsive or having difficulty breathing. V3 added that she is not quite sure, she has to look at the records again. The facility protocol when there is an emergency is to notify the physician after assessing the resident and follow orders, then notify the family and nursing management. If the staff is not able to reach the family at that time, it should be endorsed to the on-coming shift to follow up. A document presented by V1(Administrator) with an effective date of September 2016, states in part, to assure resident transfers and discharges will be conducted in accordance with resident's rights, physician orders, and in such manner as to maintain continuity of care for the resident. Under definitions, inter facility transfer (b) stated from facility to hospital. Policy specifications #2 states: when the facility transfers or discharges a resident under any circumstance, the resident/authorized representative must be notified verbally and in writing at least 30 days prior to the intended discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on interview and record review, the facility failed to ensure that a follow-up appointment was scheduled with specialists physician for a resident as ordered; they failed to administer prescribed medications and monitor and document resident's respiratory and oxygen status per physician orders and plan of care; and failed to ensure that staff accurately assess and document emergency response for a resident. This failure applied to one (R1) of one resident reviewed for nursing care. Findings include: R1 is a [AGE] year-old make admitted to the facility on [DATE] with past medical history of Rheumatoid arthritis, Hypertensive heart disease, dysphasia oral phase, coagulation defect, epistaxis, gastro -esophageal reflux disease with esophagitis without bleeding, dependent on supplemental oxygen, dyspnea, difficulty walking, etc. R1 had a cardiac arrest at the facility on [DATE], facility called a code blue, resident was later transferred to a local hospital where he died two days later. Primary cause of death was listed as anoxic brain injury, non-traumatic. Per record review, R1 was sent to the hospital on [DATE] for complaint of chest pain and returned to the facility. Nursing notes dated [DATE] 10:12 PM, states resident returned from ER via stretcher accompanied by ambulance attendants. No acute distress noted. V/S: blood pressure ,d+[DATE] T98.9 P69 R22 O2 sats 99% on 2 liters per n/c. Resident is to follow up with Pulmonologist ASAP around [DATE]. No complaints offered. Review of resident's record did not show that the appointment was scheduled or that resident saw the pulmonologist as ordered. Hospital discharge summary dated [DATE] stated that R1 is to follow up with a pulmonologist as soon as possible, for a visit in 2 days (within [DATE]). On [DATE] at 4:28PM, V3 (Director of Nursing / DON) said that when a resident returns from the hospital the clinical supervisor reviews the discharge summary and makes appropriate follow up appointments, and social services helps with that too. On [DATE] at 4:34PM, V12 (Licensed Practical Nurse / LPN) said that she is familiar with R1 but cannot remember if she made any appointment for him after he came back from the hospital, she has to look in her records. V12 later presented a documentation of facility July and [DATE] appointments, showing that R1 had a radiology appointment on [DATE], but did not have any pulmonologist appointment in the month of July or August. V12 was presented a discharge summary for R1 dated [DATE] that stated that R1 needed to see a pulmonologist as soon as possible within 2 days. V12 said that she did not schedule the appointment because under the instruction, it stated as needed, if symptoms worsen. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] at 10:46AM, V13 (LPN) said that R1 came to the nursing station (on [DATE]) and told her that he needed a breathing treatment between 8:30 and 9:30AM after breakfast, she told resident to go and wait in his room, V13 got to the room, set up the breathing treatment (Albuterol) and hooked resident up. V13 stayed in front of the room because she was giving medication to other residents. R1 was doing okay, then he slumped over, V13 called (R1's) name but he was not responding. V13 then called a code and 911; private ambulance company responded and the staff (V13 and a CNA) started chest compressions for about 30 to 40 minutes. V13 is not sure if they gave R1 any medication. V13 said that R1 had not received any medications from her prior to the code and she did not have any vitals on the resident before or during the code, the EMS took vitals. V13 and the CNA were the only people doing the chest compressions, one nurse from another unit came to the room and another one called 911. V13 stated that R1 did not have his oxygen on when he came to the nursing station to ask for breathing treatment, he is non-compliant with his oxygen and always takes it off. R1 was seen earlier that morning in the dining room but V13 is not sure if he had his oxygen on. Progress note documented by V13 (LPN) on [DATE] at 3:02PM, stated in part that R1 requested a breathing treatment, writer stayed at room door giving other residents in same room medication. R1 then started to fall to side of bed, his name was called several times with no response, writer then started chest compressions. Certified Nursing Assistant (CNA) close by called code blue another nurse called 911, chest compression's continued until EMS arrived. Resident transferred to hospital at 9:35 am. Review of physician order dated [DATE] showed Albuterol sulphate 2.5 mg/3 ml via inhalation twice a day, 6:00AM and 6:00PM, there is no order for as needed breathing treatment noted in the physician orders. [DATE] at 2:25PM, V16 (LPN) said that she is not very familiar with R1 but was working the day he was sent to the hospital. One of the nurses came and asked if she can help her assess R1, they thought it was his usual oxygen problem and adjusted his oxygen and (R1) was fine. (R1) went to his room and laid himself down, 10 to 15 minutes later, the nurse found him unresponsive and called V16 to come and help her assess the resident. R1 was unresponsive, they called a code and V16 went to get the crash cart. V16 said she was taking blood pressure and blood sugar but not sure who was recording them and that she did not record them herself. [DATE] at 10:58AM, V18 (Registered Nurse / RN) said that she is not so familiar with R1 but was at work the day they called a code on the resident. By the time V18 got to the resident's room they were already doing CPR, V18 felt a pulse and told the assigned nurse that there is a pulse, she also obtained a blood pressure which she showed to the nurse, the EMS arrived and took over and V18 left the room. V18 stated that she does not know if the nurse documented the blood pressure or if anyone else did. Physician order dated [DATE] for R1 stated: monitor blood pressure, temperature, pulse, and respiration and record every shift, oxygen ,d+[DATE] liters related to chronic obstructive pulmonary disease, oxygen saturation (pulse oximetry) every shift. R1 also has the following medication orders: Amiodarone 200mg, 1 tablet by mouth daily at 9:00AM, Carvedilol 6.25 mg 1 tablet by mouth twice a day at 9:00AM and 5:00PM, Hydrocodone-Acetaminophen , d+[DATE]mg, 1 tablet by mouth twice a day, 9:00AM and 5:00PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of medication administration record for [DATE] showed that R1 did not receive any scheduled medications that day. Also, there were no documented vital signs for the resident prior to the code blue or during the code. Care plan dated [DATE] states that R1 has potential for complications, has been noted with shortness of breath when lying flat and requires oxygen therapy R/T Dx of COPD, Dyspnea, etc. Interventions include Monitor and document respiratory/oxygenation status as scheduled/needed, Provide medications per MD's order. Explain medication regimen, actions, and side effects. Monitor effectiveness and report, administer oxygen as ordered, etc. Medication administration policy (undated) states in part; it is the policy of the facility to authorize licensed .to prepare and administer medications. #14, medications shall be administered within one hour (1) hour of medication schedule unless specifically ordered otherwise. A document provided by V1 (Administrator) titled Cardiopulmonary Resuscitation (CPR) and Basic Life Support (BLS) (undated), reads: The facility's procedure for administering CPR shall incorporate the steps covered in the American Heart Association most recent published guidance for cardiopulmonary resuscitation and emergency cardiovascular care or facility BLS training material. Under documentation, document the following in resident's medical record (if victim is a resident): the condition in which the resident was found, or the witnessed event, the sequence of resuscitation efforts, including approximate times, the victim's response to resuscitation efforts, the approximate time that the EMS team took over, time of death or time resident was transported.