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	06/20/2025

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow their abuse policy by failing to keep a resident (R2) free from being hit with a tool by another resident, failing to keep a resident (R5) free from being hit in the face, and a resident (R6) from being pushed by another resident, for three residents out of seven reviewed for abuse in a total sample of seven. Findings Include: A. R1 is a [AGE] year-old male admitted on [DATE] with diagnosis not limited to bipolar disorder, hemiplegia affecting the left side, and dementia. R2 is a [AGE] year-old male admitted on [DATE] with diagnosis of but not limited to dementia, heart failure, and Parkinson's disease. On 6/17/25 at 11:49AM, R1 was sitting in a separate dining room from R2 waiting for the lunch meal. When first asked, R1 denied having any physical altercations but then remembered once the surveyor gave R1 more details. R1 was unable to remember when the altercation occurred but reported R1 hit R2 in the arm with a pair of wire pliers in the arm. R1 stated R1 hit R2 because R2 hit R1 in the head first, and accused R2 of sizing up R1 to see how well R1 could fight. R1 reported this happened in front of the nurse's station but was not able to remember if any other staff or residents were present as witnesses. R1 stated staff separated R1 and R2 and R1 was sent to the hospital for a week because this is the punishment when you fight. R1 reported staff told R1 that R1 can't fight anyone in the facility. R1 reported R1 found the pilers in the hallway a couple days before and hid them in R1's room just in case R1 would need to defend R1's self. R1 stated the pilers were taken away by staff on the day of the altercation. The surveyor assessed R1's mental status and R1 is alert and oriented times two. R1 stated the date as June 1st and refused to state a year, the location as Chicago, IL, and R1's name correctly. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 11:55AM, R2 was sitting in a dining room waiting for the lunch meal. R2 stated R2 was hit by R1 in March 2025. R2 reported R1 and R2 were standing at the nurse's station when R1 approached R2 and hit R2 with a pair of pliers on the right wrist. R2 stated the incident was unprovoked and R2 said nothing to R1 before the incident occurred. R2 reported R2 yelled out to stop and R1 stopped hit R2 and staff came to assist. R2 denied hitting R1 before or after R1 hit R2. R2 stated R1 was sent to the hospital after the altercation. R2 denied having any other incidents with R1. R2 stated staff just told R2 to tell staff when there is any issues between R2 and any other residents before it gets physical. The surveyor assessed R2's mental status and R2 is alert and oriented times two. R2 stated the date as June 9, 2025, the location as Chicago, IL, and R2's name correctly. On 6/17/25 at 1:26PM, V3 (LPN) stated V3 was at the nurse's station. V3 reported hearing a yell and looked up to see R1 hitting R2. V3 confirmed R1 hit R2 in the arm with a pair of pliers that R1 pulled from R1's pocket. V3 denied knowing how R1 got the pliers. V3 stated this incident would be physical abuse because R1 hit R2. On 6/18/25 at 12:05PM, V10 (PRSC) stated the nurses reported to V10 that R1 hit R2 with pliers. V10 denied knowing how R1 obtained the pliers. V10 stated residents cannot have tools for safety reasons. V10 reported abuse is a form of taking advantage of people which can be verbal, physical, financial, and abuse of power. V10 stated this incident would have been physical abuse because an object was used to hit another individual. On 6/18/25 at 12:19PM, V14 (LPN) stated V14 was passing meds near the nurse's station when V14 heard commotion down the hall. V14 reported when V14 looked down the hall R1 hit R2 with some kind of tool in R2's arm. V14 defined abuse as someone physically or mentally causing harm to someone. V14 reported this incident would be physical abuse because of the hitting. V14 stated resident should not have tools because they could potentially harm themselves or someone else. On 6/18/25 1:57PM, V1 (Administrator) stated R1 hit R2 with an instrument. V1 reported staff told V1 that R1 hit R2 with a tool. V1 reported residents are not allowed to have tools in the facility. A Social Service note dated 3/7/25 documents R1 was observed being physically and verbally aggressive toward another resident. R1 was counseled and monitored for further behaviors. A Nursing note dated 3/7/25 documents at approximately 6:00 PM, R1 and R2 were coming down the hallway from the dining area after dinner. Before reaching the nurses station, R1 showed physical aggression towards R2 by hitting R2 with a tool that R1 took from maintenance. This tool was not visible during, before, or after dinner. R2 yelled and stated that R1 hit R2 gaining the attention of peers and staff. R1 was asked why R1 hit R2 and R1 stated because R2 had hit R1 first. R2 denied hitting R1. R1 received redirection and was escorted to the room. The physician ordered to send R1 to the hospital for an evaluation. The Hospital Records dated 3/8/25 document R1 admitted to the hospital for aggressive behavior. When asked what the reason for the visit was, R1 stated R1 was fighting with another guy. R1 admitted to being petitioned to the emergency department from a local nursing home for aggression. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Aggression Risk Review dated 3/10/25 documents R1 has a history of physical aggression. R1 hit R2 with a tool. Risk factors to increase aggression include change in mental status, increase or change in symptoms, and restlessness/ fidgety behavior. R1 also has a diagnosis of dementia and/ or serious mental illness. The Care Plan for R1 dated 3/10/25 documents R1 may exhibit or threaten physical aggression as R1 was involved in an incident with a peer on 3/9/25. The Minimum Data Set for R1 (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 13 (no cognitive impairment). Section E of the MDS documents R1 had not exhibited physical, verbal, or other behavioral symptoms directed towards others since the last assessment. R1 also does not experience hallucinations or delusions. A Nursing note dated 3/7/25 documents R2 was at the nurse's station when R2 was hit by another resident in the right arm. Both residents were separated and an x-ray was ordered for the right arm/hand. The Abuse Risk review dated 3/10/25 documents R2 experienced physical abuse by being hit in the arm with a tool. Continue current care plan. The Care Plan for R2 dated 4/5/25 documents R2 may be at risk for abuse living in close proximity of others. R2 may wander into the personal space of others potentially increasing the risk for abuse. R2 was involved in an incident on 3/9/25. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 10 (moderate cognitive impairment). Section E of the MDS documents R2 does not exhibit physical, verbal, or other behaviors towards others since the last assessment. R2 does not have delusions or hallucinations. The Facility Reported Incident Form dated 3/14/25 documents R1 struck R2 with an instrument. Both were separated and evaluated. R1 was sent to the hospital for a psychiatric evaluation. Staff heard a brief verbal exchange and staff began to approach R1 and R2. Upon approaching, R1 found an instrument and struck R2. R2 was x-rayed and it was negative for fracture or dislocation. R1 will be reevaluated upon admission. B. R3 is a [AGE] year old with the following diagnosis: schizoaffective disorder, epilepsy, and unspecified psychosis. R5 is a [AGE] year old with the following diagnosis: dementia, Parkinson ' s disease, heart failure, and delusional disorder. R6 is a [AGE] year old with the following diagnosis: heart failure, chronic obstructive pulmonary disease, and psychosis. R3 no longer resides in the facility. On 6/17/25 at 11:33AM, R5 was walking down the hallway with a walker. R5 was unable to communicate. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/25 at 11:45AM, R6 was sitting in the dining room waiting for lunch. R6 was unable to answer any surveyor questions. R6 was only able to spell R6's name. On 6/18/25 at 11:23AM, V8 (LPN) stated R5 had a red mark on R5's face because R5 was hit by R3. V8 reported R3 was impulsive and had behaviors of being aggressive. V8 stated R3 then went and had some kind of altercation with R6. V8 couldn't elaborate more on what happened with R6. V8 reported R3 was sent to the hospital and didn't return because the facility didn't want to keep putting other residents at risk. On 6/18/25 at 11:49AM, V9 (PRSC) stated R6 reported to V9 that R6 was in line to go smoke when R3 came up and pushed R6 unprovoked. V9 confirmed R3, R5, and R6 are alert residents that know what they are doing. V9 defined abuse as hitting someone, being aggressive, getting their money or misappropriating their funds, or not being there for them when you need them. V9 reported this incident is an aggressive physical abuse because pushing is abuse. On 6/18/25 1:57PM, V1 (Administrator) stated R3 hit R5 and then immediately went over to the dining room and pushed R6. V1 reported R3 has a history of behaviors so R3 was not welcome back at the facility after this incident. A Nursing note dated 4/14/25 documents the nurse told the ADON that R3 was physically aggressive with a peer. The nurse assessed the peer while the ADON attempted to speak with R3. The ADON was told by staff that R3 was physically aggressive with another peer in the dining room. The physician ordered to petition R3 out to the hospital for behavior management. A Social Service note dated 4/14/25 documents R3 was involved in physical aggression towards peers on separate occasions earlier in the day. R3 was provided supervision and guidance until transported out for a psychiatric evaluation. R3 was issued a thirty day notice of involuntary discharge. The Aggression Risk Review dated 3/17/25 documents R3 was involved in a physical altercation with a peer. R3 also was involved in altercations on 1/27/25 and 2/16/25. R3 is at risk for aggressive behavior due to delusions and restlessness/fidgety behavior. R3 also has a diagnosis of schizophrenia and bipolar disorder. The Care Plan dated 2/27/25 documents R3 has a history of physical behavioral symptoms towards others. R3 underwent a mental status change characterized by physically aggressive towards peers. An intervention includes staff will provide R3 1:1 sessions during periods of increased agitation. This care plan also documents R3 is at risk for abuse and neglect due to poor insight to boundaries of others related to a diagnosis of schizoaffective and bipolar disorder. The Minimum Data Set (MDS) dated [DATE] documents Brief Interview Status score of 15 (no cognitive impairment). A Nursing note dated 4/14/25 documents R5 complained that a co-peer (R3) hit R5 unprovoked. R5 had a red area to the lateral face. R5 denied any pain. Physician was notified with no new orders. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Incident Report Form dated 4/18/25 documents R3 was physically aggressive towards R5 and R6. R3 was petitioned for a psychiatric evaluation. R5 was sitting on R5's bed when R3 entered the room and without provocation hit R5 in the face. Staff intervened and separated the residents immediately. R3 left the room as staff attempted to alert the nurse of the situation. R3 proceeded to the dining room area and then pulled R6 from the wheelchair and pushed R6. No injuries were reported by any nursing staff. R5 did have some redness under the right eye. R3 was sent to the hospital for further evaluation and placed on immediate supervision until transportation arrived. The Abuse Risk Review dated 4/3/25 documents R5 is at risk for neglect. R5 does not have any documented risk factors for being abused. The Full Body Observation dated 4/14/25 documents R5 had a body assessment post altercation. R5 has bruising to the right side of the forehead. The Care Plan dated 4/4/25 documents is at risk for abuse due to living in a close proximity to peers in a health care setting. R5 was involved in an altercation with a roommate on 4/14/25. An intervention includes staff will remind R5 to follow instructions to avoid potential of being exposed to possible abuse situations. A Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 10 (moderate cognitive impairment). Section E of the MDS documents R5 does not exhibit physical, verbal, or other behaviors towards other since the last assessment. R5 does not have delusions or hallucinations. The Care Plan dated 12/12/24 documents R6 may be at risk for abuse due to impulsive behavior, verbal outbursts, and confusion. R6 was involved in an altercation with a peer on 4/14/25. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as a 12 (moderate cognitive impairment). Section E of the MDS documents R6 does not exhibit physical, verbal, or other behaviors towards other since the last assessment. R6 does not have delusions or hallucinations. A Nursing note dated 4/14/25 documents the nurse was notified by other staff that R6 had an exchange of words with a male peer (R3). Staff separated the residents and R3 was sent to the counselor ' s office to be monitored. R6 denied any pain. The Abuse Risk review dated 3/11/25 documents R6 is at risk for neglect. R6 does not have any documented risk factors for being abused. The Trauma Informed Care Observation dated 4/14/25 documents R6 was involved in an altercation. R6 was pushed by a peer. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy titled, Abuse Prevention Policy, that is not dated documents, This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents. The purpose of this policy is to assure that the facility is doing all that it is within it's controlled to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents . Abuse: abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident . Physical abuse is the infliction of an injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment.