

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/28/2026
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)		
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and follow their Abuse Prevention Policy and Procedures by failing to protect a resident (R1) from physical and verbal abuse, failed to immediately report allegations of abuse to the state agency, failed to initiate a timely investigation, and failed to take immediate actions to ensure resident safety. These failures resulted in psychosocial harm of R1 who is fearful and scared of another altercation with V5 and fearful he will be abused again. Failure of the facility not following their abuse policy puts all 147 residents at risk of being abused. The Immediate Jeopardy began on 07/05/2026 when R1 and V5 were involved in a physical altercation in the facility. V1 (Administrator) was notified on 07/20/2026 at 3:00 PM of the Immediate Jeopardy. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on 07/23/2026, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R1 is [AGE] years of age. Current diagnoses include but are not limited to Dementia with Other Behavioral Disturbance (diagnosed 10/01/2022), Type 2 Diabetes Mellitus, Chronic Kidney Disease with Heart Failure, Major Depressive Disorder, Unspecified Psychosis, Neuromuscular Dysfunction of Bladder, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Parkinson's Disease. R1's comprehensive assessment section C Cognitive Patterns dated 05/18/2026 documents a BIMS (Brief Interview for Mental Status) score of 11. R1 has moderate cognitive impairment. R1's Physician Order Report dated 06/09/2026 - 07/09/2026 states in part R1 is prescribed the following medications for Psychosis: Divalproex Delayed Release 250mg (milligrams) 1 tab oral three times a day and Haloperidol 5mg 1 tab oral once a day. R1's care plan dated 02/16/2026 states in part: R1 may display episodes of aggression, of hitting staff and peers which pose a risk to self and/or others and interferes with care provision and social interactions. Goal: R1's aggression triggers will be minimized through proactive staff intervention. Approach: 02/16/2026 Redirect to safe, calming activity when agitated. Discipline: All Disciplines, C.N.A, Nursing. Problem start date 02/16/2026 Psychosocial Well-Being: R1 may exhibit agitation vulnerabilities such as low esteem, confusion, and easily being misled/or misguided by others which may put him at risk for abuse due to his diagnosis of Dementia. On 11/19/25 a peer made allegations that the above resident was physically aggressive towards him. Goal: R1 will be free from any forms of abuse and neglect daily by next review. Approach start date 02/16/2026: 11/18/25 1:1 counseling on respecting others and privacy. Re-educated to call light for staff to use when staff assistance is needed. Allow R1 time to vent and positive feedback given. Added to 72hr well-being check. 1:1 behavior monitoring until calm. Room change completed 11/18/25 and 11/19/25. R1 will be redirected by staff as needed to ensure the safety of himself and others. Staff will intervene when R1 appears to need redirection or assistance with a task. Review of incident witness statements document in part: On 07/05/2026 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145798
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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	got mad at me and threw me down. I told V5 CNA to write the statement, and she argued with me. I have my first statement written and they told me I couldn't write that. They told me to rewrite my statement. On 07/09/2026 at 2:50 PM, V1 Administrator was inquired of the cameras observed in the hallways and common areas for video footage on Sunday 07/05/2026. V1 said, I have cameras, but they don't record anything. It's just live feed. Once it passes it doesn't record. On 07/09/2026 at 2:52 PM, V20 LPN was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V20 said, I worked the night shift, I was on the other side. The CNAs were talking about the incident. I was told V11 RN was on break. V9 LPN was there when I got there. I went over there to check on R1. V9 was at the nurse's station. I asked R1 if he was OK, he said he hit the CNA because he had to. I looked at his hands, face, and body. I went back to my side. I didn't document anything. I was asked to write a statement. I wasn't his nurse; I was just concerned. He's normally calm and cool. I've never had an issue with him. I've never heard of him (R1) having an issue with any other resident. On 07/09/2026 at 3:01 PM, R4 was inquired of hearing or seeing anything while in the room on Sunday 07/05/2026 between R1 and V5. R4 is nonverbal and shook his head from side to side indicating No. R4 was asked if he was asleep during the incident. R4 nodded his head up and down indicating Yes. On 07/13/2026 at 10:07 AM, Timecards were reviewed from all staff present during the incident on 7/5/26. V11 RN clocked out at 3:07 AM and returned at 4:17 AM. V9 was the only nurse on left on the A/B wing. Further calls made to speak with R11 with no answer or ability to leave a message. On 07/13/2026 at 10:31 AM, V5's personnel file was reviewed, abuse and dementia training completed. V23 Human Resources was inquired of V5 CNA completing CPI (Crisis Prevention Intervention) training. V23 said, V5 didn't have CPI training yet. We try to get them in within the first 60 days of hire. We offer the training every two weeks, but it can only take ten people. On 07/13/2026 at 10:36 AM, V2 Assistant Administrator was inquired of V11 RN not having a statement written and not working since 07/04/2026. V2 said, I didn't see V11 when I came in that morning. I didn't call her because staff said she was on break and wasn't there when it happened. On 07/13/2026 at 11:41 AM, V4 ADON Assistant Director of Nursing was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V4 said, I wasn't here that day. V2 Assistant Administrator told me there was an incident on Monday (07/06/2026). I helped with witness statements and contacting staff. I talked to V5 CNA over the phone on Monday. She was trying to redirect R1 and he became aggressive and hit her. I talked to V20 LPN, she said she heard a commotion and went to assess R1. We had V5 CNA take a leave while investigating, everything else was done by administration. On 07/13/2026 at 12:01 PM, V24 Family Member was inquired of being notified of the Sunday 07/05/2026 incident between R1 and V5 CNA. V24 said, I was told he (R1) made contact with staff and scratched her on the arm. He's never been violent towards anyone ever. I'd like to know more about what happened. On 07/13/2026 at 12:43 PM, V3 DON Director of Nursing was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V3 said, I was on vacation the day it happened. I returned on Monday and was made aware. The investigation was already assigned to other staff; I wasn't a part of it. When there's an incident the nurse should make sure everyone is safe, assess the resident, complete the observation form for the body and pain, notify the doctor and family, then notify administration immediately, and do a progress note. Document so you can see if something comes up, you may not be able to remember so document everything. It's to cover you as a nurse. If there's no documentation, I'd try to find out why it wasn't done. Technically if there's no documentation, it wasn't done. We train the nurses on incidents and if anything happens after hours they can contact me at any time. V4 ADON was available, and all nurses have her phone number. V4 and I are responsible to make sure all the documentation is in place. I didn't look into the documents for it (incident report) because staff said they did the investigation. I (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	should have followed up and looked at everything. On 07/13/2026 at 1:21 PM, V21 Anonymous contacted this surveyor regarding the Sunday 07/05/2026 incident between R1 and V5 CNA. V21 said, V5 came to the desk talking about what happened and said, Who came up here being messy, I don't like nobody being messy. I asked V5 why didn't she yell code white in the hall? Why did you drag him (R1) back in the room? V5 said, I knocked his ass out. I've done this on second shift, and they don't say nothing about it, why people on this shift messy. On 07/13/2026 at 3:19 PM, R1 was inquired of his shirt being ripped during the incident with V5 CNA and how he feels while V5 is in the building working. R1 said, She (V5) pulled me and ripped my shirt. She hasn't worked with me since then. I think she's gonna fight me again. I'm scared. On 07/13/2026 at 3:28 PM, V1 Administrator was inquired of the incident investigation process and V5 CNA. V1 said, Overall myself and V2 (Assistant Administrator) are responsible for the investigation. V5 CNA was off for one day then came back in. It was concluded as a resident to staff incident. I'm the abuse coordinator. I'm responsible for making sure the investigation is completed. I do interviews with residents and staff, and anyone present having information regarding it. Assessments of staff and residents if needed. Coordinate any other actions if needed, contacting doctors and family. Review statements. Come to a conclusion with the information provided. Each investigation is individual; I can't give a time frame. V5 returned to work on July 6th. On 07/13/2026 at 3:35 PM, V3 DON Director of Nursing was inquired if C.N.A.s are able to go anywhere else in the building other than their assigned unit while working. V3 said, C.N.A.s can go to other units to get supplies or if helping other staff. On 07/14/2026 at 12:24 PM, This surveyor was asked into V1 Administrator's office related to questions about the investigation. V1 said, Can you tell me who called in this investigation? V1 wanted this surveyor to tell him if it was staff and who it was. V1 said, I have some staff I need to get rid of. I know it's staff because state has been in the building for a few months and every time they (state) come in they have specific information that only staff would know. I just want to talk to them to clear up some of the information being reported to state. This surveyor told V1, According to your abuse policy anyone in this building can report an allegation of abuse. On 07/14/2026 at 12:44 PM, V10 PRSC (Psychiatric Rehab Services Coordinator) was inquired of the facility having emergency codes. V10 said, Yes, we do. It's on the back of our ID's (Identification). Code white means combative resident. V10 showed this surveyor the back of her ID badge with a list of emergency codes. Code white = combative resident. On 07/14/2026 at 1:02 PM, V2 Assistant Administrator was inquired of the facility having emergency codes and training. V2 said, The emergency codes are on the back of our badges. V2 turned her ID badge over to the back, there is a list of emergency codes. V2 said, All staff have training on the emergency codes in orientation. Surveyor requested a copy of the emergency codes for review. On 07/14/2026 at 1:18 PM, V23 HR Human Resources provided V5 CNA's signed copy of the emergency code training dated 05/28/2026 with a copy of the emergency codes. On 07/15/2026 at 12:03 PM, R4's room was reviewed for his communication book. R4's communication book is on the nightstand in his room. There are multiple pages of pictures with written descriptions listed. There is no documentation of the phrase leave me alone on any of the pages in the communication book. V8 RN Registered Nurse was inquired of R4's communication and book. V8 said, R4 is nonverbal and uses a communication book. He can demonstrate by pointing at things to call your attention. He can hear and understand what you say and nod his head. He's had the book since I've been working with him from April of this year. There aren't any pictures or words that say leave me alone. On 07/15/2026 at 12:06 PM, V8 RN was inquired of the report she received on 07/05/2026 and her documentation. V8 said, V9 LPN gave me report that morning. She said R1 was having behaviors early that morning around 5AM. V4 ADON Assistant Director of Nursing told me to do 72 hour behavior charting; we do that to see if R1 had any changes. I (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	don't know of him ever hitting or being aggressive with staff since I've been here. V4 asked me to call V25 Physician. I called V25, but he didn't answer so I left a message. V4 said R1's family was already called. When I looked in his (R1's) notes, there wasn't anything documented from V9 about the incident calling V25, the doctor or family. I documented he (R1) didn't have behaviors for my shift. Interviews were conducted with staff on 07/15/2026 between 12:48 PM - 2:02 PM. All staff did not recall R1 having any aggressive behaviors of hitting or yelling at staff to their knowledge. On 07/15/2026 at 12:56 PM, R1 was inquired how the incident started with V5 C.N.A. and how he ended up on the floor. R1 said, She (V5) swung at me first, then I swung back at her. She didn't wanna give me the towel and she got mad. She swung at me because I pissed on the floor. That's what it was about. That's why she got mad. I got on the floor cause she threw me down. On 07/15/2026 at 1:29 PM, V30 Plant Operation Manager of Housekeeping and Laundry was inquired of R1's behavior. V30 said, I've been here two years, and I work on all units. I've never seen or heard him (R1) ever be aggressive. I've never seen him hit or yell at anyone. He does urinate on the floor sometimes because he doesn't understand when he has to use the bathroom. It's usually an accident. He'll come and ask for pants. On 07/15/2026 at 1:42 PM, V32 MDS LPN was inquired of R1's behavior care plan. V32 said, R1 has Dementia with behavior disturbance since 2022 from his face sheet. His care plan for aggressive behavior was reviewed 2/16/26, but it didn't just start. For their (residents') annual care plan review we update the start dates. His progress notes from 2/16/26 say he went out to the hospital for cellulitis, and we picked him up because he needed skilled care and therapy. It wasn't for behavior. On 07/15/2026 at 1:54 PM, V33 LPN was inquired of R1's behavior. V33 said, I've been here seven years. I'm familiar with R1. He's compliant. He sings and talks to himself. He's not one to have behaviors, he doesn't act out. He's kind and respectful. He'd have to be triggered to have a behavior like that. On 07/15/2026 at 2:11 PM, V35 PRSC Psychiatric Rehab Services Coordinator was inquired of R1's behavior. V35 said, I've been here nine years, he's (R1) on my caseload. He's calm but can be agitated sometimes. I haven't seen him hit anyone, staff or resident. He'll say leave me alone. Sometimes he'll yell in the room, but I'm familiar with him. I can calm him down. I've never had to do a code white for him or ask staff to do anything. He's only upset if he doesn't get his money. On 07/15/2026 at 2:31 PM, V12 CNA was inquired of the Sunday 07/05/2026 incident. V12 said, I've been here six months. I was in the hallway getting linen and going in and out my residents' rooms. V5 and R1 were in the hall in front of R1's room. I believe it was about 5 in the morning. I didn't see it start. I heard her (V5) yelling about clothes. I heard a commotion and saw them in each other's arms. I was going towards them to break it up and I turned my head to call for help. They both fell into the room. I didn't hear him (R1). He (R1) can get anxious about his clothes, but he's normally calm. I haven't seen him aggressive or yelling at anyone. On 07/15/2026 at 2:41 PM, V14 CNA was inquired of the Sunday 07/05/2026 incident. V14 said, I was in a room when it happened. I heard a commotion in the hall and peaked my head in the hall. I heard someone say let go. I came down to the room, two staff were there breaking it up, V12 and V15. I've never seen him (R1) have any behaviors. I don't know of him ever hitting anyone. He can yell in his room when he doesn't want to get up. On 07/15/2026 at 3:08 PM, V5 CNA was inquired how the incident started with R1. V5 said, I was in his (R1) room helping with incontinent care. I was putting towels on the floor in the room. I thought it was water. He (R1) was in the bathroom. R1 told me it was pee (urine), he said he had an accident. I was redirecting him to put on his pants because he was going in the hall in his underwear and he wasn't listening. He was fidgeting. I don't remember who grabbed who first, but my arm was scratched. I said help. He became resistant and we began struggling. We lost our balance and fell. A couple of people came to help; I didn't know their names. I'm not scheduled to work on his side. I didn't get any training when I came (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	back to work. I haven't had CPI (Crisis Prevention Intervention) training yet. On 07/15/2026 at 3:30 PM, V20 LPN was inquired of assessing R1 after the incident, the lack of documentation, and of V11 RN. V20 said, I didn't ask him (R1) how he got on the floor. I'm not sure why V11 left, I just thought she was at lunch. I didn't see her. I just went there (A unit) to make sure he (R1) was OK because I work with him a lot. I was asked to write a statement. His nurse V11 wasn't here so they (administration) asked us to write a statement. He (R1) was sitting on the bed; he wasn't in distress. I didn't get vital signs. I didn't like stepping on anyone's toes. V9 LPN was at the desk. If an incident happens, I'd step in and act as the nurse. I'd check the resident, handle the emergency, do the assessment and vital signs and tell the nurse when she comes back. On 07/15/2026 at 6:05 PM, V15 Anonymous returned an interview regarding the Sunday 07/05/2026 incident between R1 and V5 CNA. V15 said, I've been there three to four years. I know him (R1). He (R1) prays loud in his bathroom. He'll pee on the floor but will help clean it up then he'll ask for clothes. He's a cool person, laid back. I've never seen him aggressive or hit anyone. I worked that night and saw two people fighting in the doorway of his (R1) room. V12 CNA said we need help down here. When I got there, it was R1 and V5 CNA. They were thrashing with each other and fell on the floor. V5 was pulling him (R1) into the room. We (V12 and V15) were trying to pull him (R1) away from V5. V5 said, I'm not no little kid. You peed on the floor; I'm not helping you no more! R1 looked shocked, his shirt was ripped in the front. It was blue. We separated them. A nurse came and asked what happened, but I don't know her name. I went and told V21 Anonymous Staff and V17 LPN, V5 just beat the mess out of R1. She was trying to pull him in the room. V5 said, I dragged him. I told V5 why didn't you leave the room. You could've came and got one of us to help him. V5 was wrong for what she did. V2 Assistant Administrator came and asked us to write statements. V2 said to put down he (R1) was aggressive but he wasn't. I usually work his set. V2 said, I don't want V5 to lose her license. On 07/16/2026 at 11:06 AM, V4 ADON was inquired about further details of the Sunday 07/05/2026 incident between V5 CNA and R1. V4 said, I didn't come in on Sunday. V2 (Assistant Administrator) called me about the incident between 5 - 7AM. I didn't come in until Monday. I called V25 Physician. I left a message because he didn't answer. I said R1 had some aggression and to call the facility to speak with the nurse or myself. V24 Physician came and rounded on Monday (7/6/26). She wrote a note on 7/7, but it didn't talk about the incident. V24's progress note was reviewed in R1's electronic medical record with V4. The nurse should have followed up with the call. V11 RN Registered Nurse was his nurse that night. V9 LPN Licensed Practical Nurse was working on the side with her. I didn't see any note about the incident. V2 just said R1 was having behaviors. I didn't speak to V9 LPN on Sunday because there were two nurses and a nurse manager there. V2 didn't ask me to come in. I spoke with V8 RN Monday. I told her to check on R1, check if he was having behaviors, and do an event which is a behavior assessment. She didn't see any display of aggression on her shift. The night shift nurse should have contacted me to call the doctor and petition R1 out. V20 LPN did his assessment but didn't document anything in his medical record. I saw she wrote she assessed him (R1) in her statement. She should have done a progress note at minimum, the assessment tab and incident note. She said he (R1) didn't have any injuries. V3 DON Director of Nursing and I called V5 CNA Certified Nurse Assistant. We asked her statement, did a one on one and told her how to be safe and remove herself from the situation. It wasn't documented, it was just verbal. On 07/16/2026 at 11:39 AM, V3 DON was inquired of updates to R1's care plan following the incident. V3 said, I wasn't a part of the conclusion, so I'd have to ask V1 Administrator. His (R1) care plan says to redirect to safe, calming activities when agitated. We automatically update the care plan on this situation. His care plan is reflective of his behavior. V5 CNA had Dementia training in orientation, but she hasn't had CPI (Crisis Prevention Intervention) (continued on next page)		

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	training yet. What should be done was to back away, redirect, have someone else take over for that resident especially if the aggression is towards them because you don't want to aggravate the resident more or have any negative situation happen. On 07/16/2026 at 12:11 PM, V2 Assistant Administrator was inquired about further details of the Sunday 07/05/2026 incident between V5 CNA and R1. V2 said, Once I got to the building I found out V11 RN had left. V9 LPN said V11 went on lunch. She (V11) wasn't seen when I got there. As a nurse, V9 LPN should have done what she was supposed to do per her managers. She (V9) should have known what her duties were. When V11 RN left, V9 was in charge of the unit. V5 CNA was sent home because of the incident with R1. I told her she's being sent home due to the investigation and would be called back upon completion. Her department heads were responsible for calling her back. I don't know if V5 received any training. On 07/16/2026 at 1:09 PM, 24 Physician was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V24 said, Someone was on call, maybe a partner took the call. I know he (R1) had a history of aggression. When I rounded, he was calm and cooperative. Our NP (Nurse Practitioner) typically works sees him. She's on leave so I'm covering for her. This was my first time seeing him (R1). None of the nurses or ADON (Assistant Director of Nursing) said anything about him having behaviors. I always talk to staff before seeing the residents. I'd like to have known about the incident, was it physical or verbal aggression. How often and what happened. What was said, if there were any falls, level of fall, medications, or obvious injury. Any pain, loss of consciousness. I'd want him evaluated and sent out also to have psych (psychiatry) see him. Was it new staff? Is there a root cause? Is this a pattern? I'd like to ask the nurse more detailed questions. I'd have them monitor and document behaviors, draw labs, and order neurological checks after a fall. They should have put in a incident report to know what happened. Agitation is something that makes you feel upset and is redirectable. Aggres[TRUNCATED]		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow their abuse and care plan (comprehensive) policy by failing to develop an individualized plan of care with measurable interventions to address a resident's episode of aggression and failed to implement the care plan interventions for aggression resulting in a physical altercation between V5 C.N.A (Certified Nurse Assistant) and R1. This failure affects one (R1) resident of four reviewed for care plan implementation. Findings include: R1 is [AGE] years of age. Current diagnoses include but are not limited to Dementia with Other Behavioral Disturbance (diagnosed 10/01/2022), Type 2 Diabetes Mellitus, Chronic Kidney Disease with Heart Failure, Major Depressive Disorder, Unspecified Psychosis, Neuromuscular Dysfunction of Bladder, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Parkinson's Disease. R1's comprehensive assessment section C Cognitive Patterns dated 05/18/2026 documents a BIMS (Brief Interview for Mental Status) score of 11. R1 has moderate cognitive impairment. Review of incident witness statements document in part: On 07/05/2026 during the 11PM - 7:30 AM between 5 AM - 6 AM, staff witnesses observed a physical altercation between R1 and V5 C.N.A Certified Nurse Assistant at the entrance to R1's room. On 07/08/2026 at 10:09 AM, R1 is alert and oriented to person. R1 is ambulatory with a rolling walker. R1 was inquired of being abused by V5 CNA. R1 said, I didn't obey her (CNA) and she threw me on the ground, my hip hurt. I peed on the floor and asked for a towel, and she got mad at me. I hit her because I had to, I didn't mean it. It was this week. On 07/08/2026 at 1:57 PM, V12 CNA was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V12 said, I was in the hall, it started in the hallway. I heard V5 CNA giving R1 commands to put his clothes on then I heard them arguing back and forth about water being on the floor. Then I heard the altercation going on. I got to the room, and they were in each other's arms. My back was turned so I don't know who started it. V5 was tussling back and forth with R1. V5 said, I look 12, but I'm not 12! I called for assistance and got them apart. The nurse and another new CNA came, I don't know their names. R1 said he was OK. He wanted to get a towel. V5 came back in the room, and I told her to leave. She went to the security desk. It happened after 5 AM. On 07/09/2026 at 9:07 AM, V5 CNA was inquired of the Sunday 07/05/2026 incident with R1. V5 said, I was doing patient care, he (R1) became aggressive asking for pants. I called for assistance from any CNA to help redirect and de-escalate. He (R1) scratched my arm and wrist. The CNAs came and de-escalated it. He (R1) calmed down and apologized. I couldn't find a nurse on my side, so I went to the other side. I made V9 LPN aware and wrote a statement. V2 Assistant Administrator came up here. I was off the schedule one day for the investigation. V2 called me back the next day and told me he (R1) admitted to what happened so I could come back. On 07/09/2026 at 10:22 AM, V2 Assistant Administrator was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V2 said, it was reported that staff said a resident attacked a CNA, so she called to report it. It was R1 and V5 CNA. When I got here, I went to the wing to check on R1. I saw V9 LPN and asked for statements. I called V1 Administrator. I witnessed all the statements and read them. I let V1 know I was in the building and what was going on. I interviewed R1 and he was apologetic, he said he hit her because he had to and was sorry. He said he was alright and wasn't in pain. R4 is R1's roommate. R4 can talk with hand movements, but he didn't wanna talk. I talked to V5 C.N.A, V15 Anonymous, V12 C.N.A, V14 C.N.A, V9 LPN and V17 LPN about what happened. Staff said they heard hollering for help and when they got there V5 and R1 were on the floor. V15 Anonymous wrote in her statement R1 and V5 were on the floor. After they were (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	separated, staff told security. V5 should have left the area when R1 became aggressive and got assistance. She shouldn't have still been in there. It should have been reported to the state then because they were tussling with each other on the floor. V9 LPN should have immediately assessed R1 and checked for safety. Separate CNA and write the statement. Document the incident and assessment. The on-coming shift shouldn't have documented on the incident, V9 should have done it. A call to the doctor should have been made to ask if R1 should go out for assessment. Family should have been called. It should have been called to the state, and we should have started our investigation. On 07/09/2026 at 2:01 PM, V21 Anonymous was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V21 said, R1 has never acted like this, it doesn't make sense. V17 LPN and I called my boss. V5 came up to the desk after it happened and said, Motherfucker's think I'm [AGE] years old. I'm not fucking playing this. I dragged his motherfucking ass. What happened to R1 isn't what's really being said. I went to the room to check on R1 after it happened. I took pictures of his shirt, it was ripped. R1 said, All I did was ask for a towel because I peed on the floor and the CNA got mad at me and threw me down. I told V5 CNA to write the statement, and she argued with me. I have my first statement written and they told me I couldn't write that. They told me to rewrite my statement. On 07/13/2026 at 3:19 PM, R1 was inquired of his shirt being ripped during the incident with V5 CNA and how he feels while V5 is in the building working. R1 said, She (V5) pulled me and ripped my shirt. She hasn't worked with me since then. I think she's gonna fight me again. I'm scared. On 07/15/2026 at 12:56 PM, R1 was inquired how the incident started with V5 C.N.A. and how he ended up on the floor. R1 said, She (V5) swung at me first, then I swung back at her. She didn't wanna give me the towel and she got mad. She swung at me because I pissed on the floor. That's what it was about. That's why she got mad. I got on the floor cause she threw me down. On 07/15/2026 at 1:42 PM, V32 MDS LPN was inquired of R1's behavior care plan. V32 said, R1 has Dementia with behavior disturbance since 2022 from his face sheet. His care plan for aggressive behavior was reviewed 2/16/26, but it didn't just start. For their (residents') annual care plan review we update the start dates. His progress notes from 2/16 say he went out to the hospital for cellulitis, and we picked him up because he needed skilled care and therapy. It wasn't for behavior. On 07/15/2026 at 3:08 PM, V5 CNA was inquired how the incident started with R1. V5 said, I was in his (R1) room helping with incontinent care. I was putting towels on the floor in the room. I thought it was water. He (R1) was in the bathroom. R1 told me it was pee (urine), he said he had an accident. I was redirecting him to put on his pants because he was going in the hall in his underwear and he wasn't listening. He was fidgeting. I don't remember who grabbed who first, but my arm was scratched. I said help. He became resistant and we began struggling. We lost our balance and fell. A couple of people came to help; I didn't know their names. I'm not scheduled to work on his side. I didn't get any training when I came back to work. I haven't had CPI (Crisis Prevention Intervention) training yet. On 07/16/2026 at 11:39 AM, V3 DON was inquired of updates to R1's care plan following the incident. V3 said, I wasn't a part of the conclusion, so I'd have to ask V1 Administrator. His (R1) care plan says to redirect to safe, calming activities when agitated. We automatically update the care plan on this situation. His care plan is reflective of his behavior. V5 CNA had Dementia training in orientation, but she hasn't had CPI (Crisis Prevention Intervention) training yet. What should be done was to back away, redirect, have someone else take over for that resident especially if the aggression is towards them because you don't want to aggravate the resident more or have any negative situation happen. On 07/27/2026 at 9:25 AM, V10 PSRC was inquired of R1's aggression care plan initiation and interventions. V10 said, He went out to the hospital on [DATE] and he returned 06/25/2025 and he had a significant change, and his care plan was updated. V10 checked R1's progress notes and said, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	He went to the hospital for hyponatremia, vomiting, and hypochloremia. I'm not sure when this care plan was started, I can't find the date. There could've been more approaches or interventions added for him. When we do his quarterly review, we ask him questions about what he likes. He asks a lot of questions. He goes to activities often. He enjoys listening to music and going on nature walks. He goes to rehab and listens to music too. He also likes smoke breaks. I don't know what his triggers are. R1's MDS Minimum Data Set (Comprehensive Assessment) Section E Behavior reviewed from January 2022 - May 2026 does not document any behavioral symptoms (physical, verbal, or self-directed) identified during assessments. R1's care plan dated 02/16/2026 states in part: R1 may display episodes of aggression, of hitting staff and peers which pose a risk to self and/or others and interferes with care provision and social interactions. Goal: R1's aggression triggers will be minimized through proactive staff intervention. Approach: 02/16/2026 Redirect to safe, calming activity when agitated. Discipline: All Disciplines, C.N.A, Nursing. R1's care plan is not individualized and person centered with measurable interventions as it does not document any triggers to his aggression. The care plan does not identify R1's preferences of activities, hobbies or thoughts on his likes and dislikes to assist with identifying ways to calm R1. V5 CNA did not follow R1's care plan approach regarding his episodes of aggression. V5 continued to engage with R1 triggering an altercation. The updated October 2022 Care Plans (Comprehensive) policy states in part: Policy: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and/or psychological needs is developed for each resident. Policy Specifications: The facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or his/her representative, develops and maintains a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain. The Interdisciplinary Team documents in the CAAs (Care Area Assessment) summary and/or the clinical record: a. the resident's status in triggered CAA area. b. The team's rationale for deciding whether to proceed with care planning. c. Evidence that the team considered the development of care planning interventions for all CAAs triggered by the MDS. Each resident's Comprehensive Care Plan has been designed to: Incorporate identified problem areas Incorporate risk factors associated with identified problems Build on the residents' strengths Reflect treatment goals and objectives in measurable outcomes Identify the professional services that are responsible for each element of care Aid in preventing or reducing declines in the resident's functional status and/or functioning levels Enhance the optimal functioning of the residents by focusing on a rehabilitative program, as needed Be respectful of a resident's health beliefs, practices and cultural and linguistic needs Reflect the resident's needs and preferences and align with the resident's cultural identity Recognize the effects of past trauma on residents and collaborate with the resident, family and friends of the resident to identify and implement individualized interventions. Care plans are revised as changes in the resident's condition dictates. The Abuse and Retaliation Policy Prevention Program dated 1-2026 states in part: Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, retaliation, misappropriation of property, and mistreatment of residents. In order to do so, the facility as attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment of residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment; Identifying occurrences and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patterns of potential mistreatment.IV. Establishing a Resident Sensitive EnvironmentThis facility desires to prevent abuse, neglect, exploitation, mistreatment, retaliation, deprivation of goods and services by staff, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers, and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches that would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches regularly and update as necessary.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to follow their abuse and care plan (comprehensive) policy by failing to revise the care plan approach (interventions) after a physical altercation between R1 and V5 C.N.A (Certified Nurse Assistant) occurred. This failure affects one (R1) resident of four reviewed for care plan revision. Findings include: R1 is [AGE] years of age. Current diagnoses include but are not limited to Dementia with Other Behavioral Disturbance (diagnosed 10/01/2022), Type 2 Diabetes Mellitus, Chronic Kidney Disease with Heart Failure, Major Depressive Disorder, Unspecified Psychosis, Neuromuscular Dysfunction of Bladder, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Parkinson's Disease. R1's comprehensive assessment section C Cognitive Patterns dated 05/18/2026 documents a BIMS (Brief Interview for Mental Status) score of 11. R1 has moderate cognitive impairment. Review of incident witness statements document in part: On 07/05/2026 during the 11PM - 7:30 AM between 5 AM - 6 AM, staff witnesses observed a physical altercation between R1 and V5 C.N.A Certified Nurse Assistant at the entrance to R1's room. On 07/15/2026 at 1:42 PM, V32 MDS LPN was inquired of R1's behavior care plan. V32 said, R1 has Dementia with behavior disturbance since 2022 from his face sheet. His care plan for aggressive behavior was reviewed 2/16/26, but it didn't just start. For their (residents) annual care plan review we update the start dates. His progress notes from 2/16 say he went out to the hospital for cellulitis, and we picked him up because he needed skilled care and therapy. It wasn't for behavior. On 07/16/2026 at 11:39 AM, V3 DON was inquired of updates to R1's care plan following the incident. V3 said, I wasn't a part of the conclusion, so I'd have to ask V1 Administrator. His (R1) care plan says to redirect to safe, calming activities when agitated. We automatically update the care plan on this situation. His care plan is reflective of his behavior. V5 CNA had Dementia training in orientation, but she hasn't had CPI (Crisis Prevention Intervention) training yet. What should be done was to back away, redirect, have someone else take over for that resident especially if the aggression is towards them because you don't want to aggravate the resident more or have any negative situation happen. On 07/09/2026 at 10:22 AM, V2 Assistant Administrator was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V2 said, It was reported that staff came and said a resident attacked a CNA, so she called to report it. I called V1 Administrator. It should have been reported to the state then because they were tussling with each other on the floor. V9 LPN should have immediately assessed R1 and checked for safety. Separated CNA and write the statement. Document the incident and assessment. The on-coming shift shouldn't have documented on the incident, V9 should have done it. A call to the doctor should have been made to ask if R1 should go out for assessment. Family should have been called. It should have been called to the state, and we should have started our investigation. On 07/27/2026 at 9:25 AM, V10 PSRC was inquired of R1's aggression care plan and interventions. V10 said, After an incident or behavior the care plan is supposed to be updated, I change the date. I'm not sure if we should be adding anything when we update it. On 07/27/2026 at 9:40 AM, V36 Clinical Director of Social Work was inquired of R1's aggression care plan and interventions. V36 said, We update the approaches and interventions. It should be done with each incident or behavior. R1's MDS Minimum Data Set (Comprehensive Assessment) Section E Behavior reviewed from January 2022 - May 2026 does not document any behavioral symptoms (physical, verbal, or self-directed) identified during assessments. R1's care plan dated 02/16/2026 states in part: R1 may display episodes of aggression, of hitting staff and peers (continued on next page)		

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 07/28/2026
NAME OF PROVIDER OR SUPPLIER Countryside Nursing & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1635 East 154th Street Dolton, IL 60419	
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which pose a risk to self and/or others and interferes with care provision and social interactions. Goal: R1's aggression triggers will be minimized through proactive staff intervention. Approach: 02/16/2026 Redirect to safe, calming activity when agitated. Discipline: All Disciplines, C.N.A, Nursing. R1's care plan was last reviewed/revise on 07/06/2026 by V35 PRSC Psychiatric Rehab Services Coordinator but the approach/interventions were not updated to reflect the recent 07/05/2026 physical altercation with staff.On 7/28/2026 at 12:16 PM, V36 Clinical Director of Social Work provided a copy of R1's updated care plan.R1's 07/23/2026 care plan approaches were updated as follows: 1:1 counseling. Allow R1 time to express his feelings and give positive feedback. Talk with a calm tone when speaking with R1. Validate R1's feelings and ensure his safety. It was updated thirteen days after the incident.The Abuse and Retaliation Policy Prevention Program dated 1-2026 states in part:Policy: This facility affirms the right of our residents to be free from abuse, neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, retaliation, misappropriation of property, and mistreatment of residents. In order to do so, the facility as attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of neglect, exploitation, retaliation, misappropriation of property, deprivation of goods and services by staff, or mistreatment of residents. This will be done by: Establishing an environment that promotes resident sensitivity, resident security, and prevention of mistreatment; Identifying occurrences and patterns of potential mistreatment.IV. Establishing a Resident Sensitive EnvironmentThis facility desires to prevent abuse, neglect, exploitation, mistreatment, retaliation, deprivation of goods and services by staff, and misappropriation of resident property by establishing a resident sensitive and resident secure environment. This will be accomplished by a comprehensive quality management approach involving the following: Resident Assessment: As part of the resident's life history on the admission assessment, comprehensive care plan, and MDS assessments staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment, history of trauma or misappropriation of resident property, who have needs, triggers, and behaviors that might lead to conflict. Through the care planning process, staff will identify any problems, goals, and approaches that would reduce the chances of abuse, neglect, exploitation, mistreatment or misappropriation of resident property for these residents. Staff will continue to monitor the goals and approaches regularly and update as necessary.The updated October 2022 Care Plans (Comprehensive) policy states in part:Policy: An individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and/or psychological needs is developed for each resident.Policy Specifications:The facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or his/her representative, develops and maintains a comprehensive care plan for each resident that identified the highest level of functioning the resident may be expected to attain.The Interdisciplinary Team documents in the CAAs (Care Area Assessment) summary and/or the clinical record: a. the resident's status in triggered CAA area. b. The team's rationale for deciding whether to proceed with care planning. c. Evidence that the team considered the development of care planning interventions for all CAAs triggered by the MDS.Each resident's Comprehensive Care Plan has been designed to:Incorporate identified problem areasIncorporate risk factors associated with identified problemsBuild on the residents' strengthsReflect treatment goals and objectives in measurable outcomesIdentify the professional services that are responsible for each element of careAid in preventing or reducing declines in the resident's functional status and/or functioning levelsEnhance the optimal functioning of the residents (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by focusing on a rehabilitative program, as neededBe respectful of a resident's health beliefs, practices and cultural and linguistic needsReflect the resident's needs and preferences and align with the resident's cultural identityRecognize the effects of past trauma on residents and collaborate with the resident, family and friends of the resident to identify and implement individualized interventions.Care plans are revised as changes in the resident's condition dictates.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide care and services according to accepted standards of practice by not following their charting and documentation policy and the Licensed Practical Nurse Job Description. The facility failed to document an altercation between R1 and V5 C.N.A (Certified Nurse Assistant) in R1's medical record and complete an incident report per the facility policy. This failure to document the staff and resident altercation caused a lack of investigation into the incident and report of suspected abuse to the state surveying agency by administration. This failure affects one (R1) resident of four reviewed for charting and documentation of incidents. Findings include:R1 is [AGE] years of age. Current diagnoses include but are not limited to Dementia with Other Behavioral Disturbance (diagnosed 10/01/2022), Type 2 Diabetes Mellitus, Chronic Kidney Disease with Heart Failure, Major Depressive Disorder, Unspecified Psychosis, Neuromuscular Dysfunction of Bladder, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, and Parkinson's Disease.R1's comprehensive assessment section C Cognitive Patterns dated 05/18/2026 documents a BIMS (Brief Interview for Mental Status) score of 11. R1 has moderate cognitive impairment.R1's Physician Order Report dated 06/09/2026 - 07/09/2026 states in part R1 is prescribed the following medications for Psychosis: Divalproex Delayed Release 250mg (milligrams) 1 tab oral three times a day and Haloperidol 5mg 1 tab oral once a day.R1's care plan dated 02/16/2026 states in part: R1 may display episodes of aggression, of hitting staff and peers which pose a risk to self and/or others and interferes with care provision and social interactions. Goal: R1's aggression triggers will be minimized through proactive staff intervention. Approach: 02/16/2026 Redirect to safe, calming activity when agitated. Discipline: All Disciplines, C.N.A, Nursing.Problem start date 02/16/2026 Psychosocial Well-Being: R1 may exhibit agitation vulnerabilities such as low esteem, confusion, and easily being misled/or misguided by others which may put him at risk for abuse due to his diagnosis of Dementia. On 11/19/25 a peer made allegations that the above resident was physically aggressive towards him. Goal: R1 will be free from any forms of abuse and neglect daily by next review. Approach start date 02/16/2026: 11/18/25 1:1 counseling on respecting others and privacy. Re-educated to call light for staff to use when staff assistance is needed. Allow R1 time to vent and positive feedback given. Added to 72hr well-being check. 1:1 behavior monitoring until calm. Room change completed 11/18/25 and 11/19/25. R1 will be redirected by staff as needed to ensure the safety of himself and others. Staff will intervene when R1 appears to need redirection or assistance with a task. Review of incident witness statements document in part: On 07/05/2026 during the 11PM - 7:30 AM shift between 5 AM - 6 AM, staff witnesses observed a physical altercation between R1 and V5 C.N.A Certified Nurse Assistant at the entrance to R1's room. On 07/08/2026 at 10:09 AM, R1 is alert and oriented to person. R1 is ambulatory with a rolling walker. R1 was inquired of being abused by V5 CNA. R1 said, I didn't obey her (CNA) and she threw me on the ground, my hip hurt. I peed on the floor and asked for a towel, and she got mad at me. I hit her because I had to, I didn't mean it. It was this week.On 07/08/2026 at 11:55 AM, V8 RN (Registered Nurse) was inquired of her progress note on 7/5/2026 regarding R1's behavior. V8 said, I got report from V9 LPN (Licensed Practical Nurse) and she said she heard some loud speaking down the hall; the CNAs were in front of R1's room. R1 was agitated. I didn't see any agitation from him.On 07/08/2026 at 1:18 PM, V10 PRSC was inquired of her 7/6/2026 observation note regarding R1. V10 said, I was told not to complete that note in the computer, that's why it's still open. I don't recall who told me not to complete it. I was told to do it because there was an incident with a resident and staff (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member R1 and a CNA, but I don't know her name. It happened on overnight shift. I came in at 9AM. I was told a resident was physically aggressive with a staff member. I attempted to speak with R1, but he talked around it. It was around 10 or 11 AM, he didn't appear to be in distress. I tried to speak with him after the incident, but he wouldn't tell me what happened. He has a behavior of praying loud in the shared bathroom and ignoring staff often. He doesn't follow directions from staff. I didn't speak with the staff, I never see third shift, they leave before I get here in the morning. On 07/08/2026 at 1:48 PM, V9 LPN Licensed Practical Nurse was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V9 said, I wasn't aware of what happened, I got there towards the end. I was at the nurse's station watching over the fall risk residents. I heard a noise from the hallway. Three CNAs were with them. Everything ended by the time I got there. Another nurse came in and interviewed R1. One of the residents was trying to get up so I ran back to the nurse's station. I wasn't R1's nurse that night. His nurse was on break. V11 RN is written as assigned to A wing on the 07/05/2026 schedule. On 07/08/2026 at 2:43 PM, V18 LPN was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V18 said, I went to lunch a little bit before 5AM. There was an incident with a resident and staff. I was told V2 Assistant Administrator was informed. I didn't speak to staff. I was done. On 07/09/2026 at 10:22 AM, V2 Assistant Administrator inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V2 said, It was reported staff said a resident attacked a CNA so she called to report it. It was R1 and V5 CNA. I saw V9 LPN and asked for statements. I called V1 Administrator. Staff said they heard hollering for help and when they got there V5 and R1 were on the floor. V9 LPN should have immediately assessed R1 and checked for safety. Separate CNA and write the statement. Document the incident and assessment. The on-coming shift shouldn't have documented on the incident, V9 should have done it. On 07/09/2026 at 11:55 AM, V1 was inquired of the incident report, R1 assessment, doctor and family notification documentation not being completed. V1 said, I looked for the progress note or incident report. I didn't find anything from the nurse that worked the shift. V8's time sheet reflects working 07/06/2026 7AM-3:30 PM shift. V9's time sheet reflects working 11PM-7:30 AM shift on 07/05/2026. V11's time sheet reflects working 11PM-7:30 AM shift on 07/05/2026. On 07/09/2026 at 2:52 PM, V20 LPN was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V20 said, I worked the night shift, I was on the other side. The CNAs were talking about the incident. I was told V11 RN was on break. V9 LPN was there when I got there. I went over there to check on R1. V9 was at the nurse's station. I asked R1 if he was OK, he said he hit the CNA because he had to. I looked at his hands, face, and body. I went back to my side. I didn't document anything. I was asked to write a statement. I wasn't his nurse; I was just concerned. On 07/13/2026 at 10:07 AM, V9 was the only nurse on left on the A/B wing. Further calls were made to speak with V11 with no answer or ability to leave a message. On 07/13/2026 at 10:36 AM, V2 Assistant Administrator was inquired of V11 RN not having a statement written. V2 said, I didn't see V11 when I came in that morning. I didn't call her because staff said she was on break and wasn't there when it happened. V9 LPN was there. On 07/13/2026 at 12:43 PM, V3 DON Director of Nursing was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V3 said, I was on vacation the day it happened. I returned on Monday and was made aware. The investigation was already assigned to other staff; I wasn't a part of it. When there's an incident the nurse should make sure everyone is safe, assess the resident, complete the observation form for the body and pain, notify the doctor and family, then notify administration immediately, and do a progress note. Document so you can see if something comes up, you may not be able to remember so document everything. It's to cover you as a nurse. If there's no documentation, I'd try to find out why it wasn't done. Technically if there's no documentation, it wasn't done. We train the nurses on incidents if (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything happens after hours, they can contact me at any time. V4 ADON was available, and all nurses have her phone number. V4 and I are responsible to make sure all the documentation is in place. I didn't look into the documents for it (incident report) because staff said they did the investigation. I should have followed up and looked at everything. On 07/13/2026 at 3:28 PM, V1 Administrator was inquired of the incident investigation process and V5 CNA. V1 said, Overall myself and V2 (Assistant Administrator) are responsible for the investigation. On 07/15/2026 at 12:06 PM, V8 RN was inquired of the report she received on 07/05/2026 and her documentation. V8 said, V9 LPN gave me report that morning. She said R1 was having behaviors early that morning around 5AM. V4 ADON Assistant Director of Nursing told me to do 72 hour behavior charting; we do that to see if R1 had any changes. When I looked in his (R1's) notes, there wasn't anything documented from V9 about the incident, calling V25, the doctor or family. On 07/15/2026 at 3:30 PM, V20 LPN was inquired of assessing R1 after the incident and the lack of documentation. V20 said, He (R1) was sitting on the bed, he wasn't in distress. I didn't get vital signs. I didn't like stepping on anyone's toes. V9 LPN was at the desk. If a incident happens, I'd step in and act as the nurse. I'd check the resident, handle the emergency, do the assessment and vital signs and tell the nurse when she comes back. On 07/16/2026 at 11:06 AM, V4 ADON was inquired about further details of the Sunday 07/05/2026 incident between V5 CNA and R1. V4 ADON said, V11 RN Registered Nurse was his nurse that night. V9 LPN Licensed Practical Nurse was working on the side with her. I didn't see any note about the incident. V2 just said R1 was having behaviors. I didn't speak to V9 LPN on Sunday. The night shift nurse should have contacted me to call the doctor and petition R1 out. V20 LPN did his assessment but didn't document anything in his medical record. I saw she wrote she assessed him (R1) in her statement. She should have done a progress note at minimum, the assessment tab, and incident note. On 07/16/2026 at 12:11 PM, V2 Assistant Administrator was inquired about further details of the Sunday 07/05/2026 incident between V5 CNA and R1. V2 said, Once I got to the building I found out V11 RN had left. V9 LPN said V11 went on lunch. She (V11) wasn't seen when I got there. As a nurse, V9 LPN should have done what she was supposed to do per her managers. She (V9) should have known what her duties were. When V11 RN left, V9 was in charge of the unit. On 07/16/2026 at 1:09 PM, V24 Physician was inquired of the Sunday 07/05/2026 incident between R1 and V5 CNA. V24 said, This was my first time seeing him (R1). None of the nurses or ADON (Assistant Director of Nursing) said anything about him having behaviors. I always talk to staff before seeing the residents. I'd like to have known about the incident, was it physical or verbal aggression. They should have put in a incident report to know what happened. There is no nursing progress note documenting the altercation between R1 and V5 C.N.A on 07/05/2026. There is no internal incident report documenting the altercation between R1 and V5 C.N.A on 07/05/2026. V9 LPN was the nurse on duty while V11 RN was out of the facility on break when the altercation between R1 and V5 C.N.A took place. V9 did not complete an internal incident report documenting the altercation and did not document the incident in R1's medical record. V20 LPN's employee statement documents an assessment of R1 was completed but there is no documentation in R1's medical record. The Licensed Practical Nurse Job Description states in part: Purpose: the primary purpose of this position is to - Supervise the day-to-day C.N.A services for assigned unit to assure that care is being rendered in accordance with current federal, state, and local standards, guidelines and regulations. Duties/Responsibilities/Function: 4. Closely monitor and supervise all facility residents per facility policies and as warranted by good nursing judgment. 6. Make written and oral reports/recommendation concerning the activities of your shift as required. 11. Ensure the appropriate documentation/charting is completed as required and in accordance with established policies and procedures. V9 LPN signed the LPN Job Description on (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/16/2026. V20 LPN signed the LPN Job Description on 10/09/2025. The undated Charting and Documentation Policy states in part: Policy Statement: All services provided to the resident; or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Policy Interpretation and Implementation 2. Entries may only be recorded in the resident's clinical record by licensed personnel (e.g. RN, LPN/LVN, QMA, physicians, therapists, etc.) in accordance with state law and facility policy. Certified Nurse Assistants may only make entries in the resident's medical chart as permitted by facility policy. 3. All incidents, accidents, or changes in the resident's condition must be recorded.		