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	07/31/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation interview and record review, the facility failed to ensure a resident's urinary drainage bag was covered in a manner that promotes dignity. This failure affects 1 resident (R150) in a sample of 68.Findings include:R150's Minimum Data Set (7/21/25) documents in part that R150 has a brief interview of mental status summary score of 11, indicating that R150 has cognitive impairment and that R150 utilizes an indwelling catheter. On 7/28/2025 at 9:59 AM, R150 was observed lying in bed with an uncovered urinary drainage bag hanging from the frame of the bed. Approximately 500 mL of straw-colored urine was observed in the bag. R150 stated that the facility staff have not kept the drainage bag in a privacy bag while in bed.On 7/28/2025 at 10:01 AM, V2 (Director of Nursing) observed the uncovered urinary drainage bag and affirmed that the drainage bag was not stored in a manner that promotes resident dignity. V2 stated that the facility standard is that all resident's urinary drainage bags are kept in privacy bag to promote privacy.Facility policy titled, Resident Rights Guideline (revised 10/2023) documents in part (residents have) the right to be treated with dignity and respect .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that advance directives were accurately completed and consistently maintained for 5 residents (R17, R55, R69, R92, and R145) reviewed for Advance Directives in a sample of 68 residents, resulting in discrepancies between documented wishes and care provided. R17 is [AGE] years old and have resided at the facility since [DATE], past medical history includes, but not limited to type 2 diabetes, hyperlipidemia, unspecified bipolar disorder, essential primary hypertension, iron deficiency anemia, etc. [DATE] 11:42 AM, per record review, R17 had an advance directive in the system that was signed [DATE], but there was no selection for the type of treatment indicated in the form. [DATE] 11:40 AM, Surveyor presented this observation to V2(DON) and she said that there should be an indication for the type of treatment required for the resident to help the staff in determining what to do in an emergency. Resident's completed advance directives should be uploaded in their medical record. Findings include: R55's undated Physician Order For Life-Sustaining Treatment (POLST) Form, records a selection for Attempt Resuscitation/CPR (Selecting CPR mean Full Treatment in Section B). However, Section B of the same undated form incorrectly indicates a choice for Selective Treatment: Primary goal of treating medical conditions with selected medical measures. R69's undated Order For Life-Sustaining Treatment (POLST) Form does not contain any selections in Sections A, B, C, or D. However, the form is signed by both R69 and the physician. R92's Order For Life-Sustaining Treatment (POLST) Form, dated [DATE], does not contain any selections in Sections A, B, C, or D. However, the form is signed by both R92 and the physician. R145's undated Order For Life-Sustaining Treatment (POLST) Form does not contain any selections in Sections A, B, C, or D. However, the form is signed by both R145 and the physician. On [DATE] at 12:25pm, V4 (Social Services Director) said, Yes, R55's POLST is not documented right. I'll (V4) have that fixed. Of course, the forms should be filled out completely. I'm (V4) not sure what happened with these (R69, R92 and R145 POLST forms). If the POLST forms are not completed and completed correctly the hospital and our facility won't know what to do. Facility policy titled, Advance Directives, undated, documents, in part, . Policy: It is the policy of this facility to allow the resident, authorized legal representative or next of kin to make decisions regarding health care, per Indiana law. Advanced Directives shall not be required as a provision of service or admission. To acknowledge and honor the resident's decision to the extent permissible under state law. To enhance a resident's quality of life by supporting resident's decisions and choices about their planned course of care, to the extent possible by facility policy and state laws. 2. At the time of admission, the Social Service Director shall provide each resident or their legal representative, educational information regarding state and federal laws. Information shall include (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	copies of the following: a. The state developed written description of the law concerning Advance Directives is Your Right to Decide b. Copy of the facility's Advance Directives Policy. 3. Facility staff will refer residents, families or legal representatives to the resident's personal physician and/or attorney for discussion and assistance regarding Advance Directives and decisions regarding life-sustaining measures. In no event shall staff give legal advice on the need for preparation of health care directives. 4. The adult competent resident, their legal representative or individual who has been authorized as the resident's health care representative will be asked if an Advanced Directive, recognized under state law, has been executed. Documentation concerning this inquiry and the individual's response shall include the date the inquiry was made and the individual making the inquiry. This information shall then be documented in the resident's medical record in the Social Service Progress Notes. The resident's Advance Directives shall be copied and maintained in the resident's medical record. An acknowledgment of receipt of information concerning Advance Directives and related state laws will also be maintained in the resident's medical record. 17. Advance Directive(s) shall be reviewed by the interdisciplinary team when completing the comprehensive assessment and addressed on the resident's plan of care, physician progress notes, physician's orders and in Social Service progress notes. 23. A copy of the original order and related physician progress notes regarding Advance Directives shall be maintained in the medical record with advance directive documents. 25. Each medical record binder will be labeled in such a manner to quickly identify Advance Directive(s). 27. Social Service and Medical Record Departments shall conduct Quality Assurance activities and report to Quality Assurance Committee.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 resident's (R92) personal and medical information was kept confidential. This failure affects 1 resident (R92) out of a sample of 68 residents reviewed for personal privacy and confidentiality of records.Findings include:On 7/28/25 at 10:11am, during a tour of R92's room, surveyor observed a paper posted directly above R92's bed. The paper documents, in part, (Name of Company that performs PASARRs/ Preadmission Screening and Annual Resident Review); R9's full name; Full name and address of the facility R9 resides at; and stated that R92 is a [NAME] Class Member and R92 requested to not proceed to assessment. R92's room is semi-private, and the information was clearly visible to visitors, staff, and the other resident in the room.On 7/28/25 at 10:11am, R92 said, I (R92) don't know what that paper is. The nurse put it up there.R92's face sheet documents diagnoses that include, but are not limited to major depressive disorder, borderline personality disorder, and mild intellectual disabilities. R92's BIMS (Brief Interview for Mental Status) score, dated 5/16/25, documents a score of 5, which indicates that R92's cognition is severely impaired.On 7/29/25 at 9:23am, during a tour of R92's room, surveyor again observed the paper with R92's personal and medical information posted directly above R92's bed.On 7/30/25 at 2:17pm, V2 (Director of Nursing/DON) stated that we (staff) don't usually put information like this above residents' beds for privacy and his (R92) is a shared room.Upon review of R92's EMR (electronic medical record), there was no documentation indicating R92 had consented to having personal medical information posted in view of others.Facility policy titled, HIPAA (Health Insurance Portability and Accountability Act), undated, documents, in part, HIPAA law ensures medical records remain confidential by requiring covered entities to implement safeguards to protect PHI. Such covered entities include healthcare providers, health plans, and healthcare clearinghouses, among others. Further, HIPAA law outlines specific requirements these entities must follow to ensure the confidentiality, integrity, and availability of PHI. Some of these requirements include: 1. Privacy Rule: This rule establishes national standards for protecting the privacy of PHI. It outlines how PHI can be used, disclosed, and accessed by covered entities and their business associates. Criminal penalties can result in fines and imprisonment. Criminal penalties are enforced by the Department of Justice (DOJ), and can be imposed on individuals who knowingly obtain or disclose PHI without authorization.Facility policy titled, Resident Rights Guideline, dated 10/2023, documents, in part, Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related services at all times. Privacy and Confidentiality.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based upon observation, interview, and record review the facility failed to follow policy procedures and failed to provide a clean, homelike, odor free, and functional environment for three of 68 residents (R127, R129, R140) in the sample and failed to maintain sanitary conditions in the community bathrooms, hallways, and other common areas. Findings include: The (7/28/25) facility census includes 158 residents. On 7/28/25 at 9:44am, surveyor inquired about facility concerns R127 stated The bathroom is a s**t show with gnats in there and affirmed the community shower is filthy and smells bad. On 7/28/25 at 10:01am, a pullup was observed on R140's bedroom floor and a thick clump of dirt was lying next to it. The pullup appeared to be stepped on (smeared dirt was noted on the outside). Trash was covering R140's dresser and was also noted on the floor. Surveyor inquired what was on R140's floor V10 (CNA/Certified Nursing Assistant) subsequently entered the room and responded, There's a brief right here, and a piece of paper then picked up several items from the floor and stated This looks like dirt ma am, he (R140) doesn't let anybody come into his room however nobody was in the room prior to observation. Surveyor inquired about the trash on R140's dresser V10 responded I see a lot of cups and pieces of paper. On 7/28/25 at 12:20pm, the (Unit B) hallway floors were notably soiled with dirt and grime. V9 (Housekeeping) was observed mopping the floor however the dirt and grime remained on the floor while proceeding down the hallway. On 7/29/25 at 9:25am (the following day), surveyor inquired about the appearance of the (Unit B) hallway floor V16 (Housekeeping) stated It looks like dirt and paint. You gotta use the stripper, buff it, and wax. V16 affirmed that the night shift staff are assigned to buff the floors but its not getting done. The (undated) housekeeping policy states it is the policy of this facility to maintain a clean, odor free, comfortable, and orderly environment in all healthcare and public areas, which meet the sanitation needs of facility and resident's rights for a safe, clean, comfortable home-like environment. The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt, and hazards. Cleaning schedules and procedures are maintained and accessible to housekeeping personnel will be adhered to. On 7/28/2025 at 10:40 AM, observed a strong odor of urine in the A/B unit bathroom and the handle to the shower within the shower room was broken off. Additionally, over 50% of the flooring of the common area in units A/B was covered in food debris and black dirt/other stains. V2 (Director of Nursing) affirmed that the shower room smelled of urine and needed to be cleaned. V2 observed the dirt on the floor and stated that the residents bring in dirt from the outside and track it throughout the facility. V2 affirmed that the floor and bathroom needed to be cleaned. On 7/28/2025 at 12:23 PM, residents were observed eating within the dining room. The ceiling of the dining room (approximately a 10-foot diameter) over resident tables was observed with ceiling tiles off and unidentified liquids steadily dripping from the ceiling. A bucket was observed on the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ground and puddles were observed around the bucket. Residents were observed ambulating under the leaking ceiling and through the puddles. R130 was observed walking through the puddles and the liquid dripping from the ceiling landed on R130's body and R130's lunch tray that R130 was carrying. R130 appeared startled and stated, it just leaked all on me. On 7/28/2025 at 1:22 PM, a facility tour was completed with V7 (Maintenance Director). V7 observed the shower rooms in both the A/B and C/D unit and affirmed that the shower faucet handles were both in disrepair. V7 was unaware of the handles in disrepair. V7 observed the leaking ceiling in the dining room, stated that the leak is from the HVAC system and that the facility is working on getting it fixed. V7 stated that staff should be moving residents away from the leaks. Over 50% of the flooring of the common area in units A/B was covered in food debris and black dirt/other stains. V7 affirmed that the stains were from the flooring needing to be stripped and waxed. Surveyor took a tissue and wiped the floor stains where the tissue turned black. V7 observed the tissue and affirmed the tissue turned black from dirt on the floor. V7 affirmed that the floor was dirty and needed to be cleaned. On 7/30/2025 at 9:52 AM, black dirt stains were observed around the nursing station. V37 (Housekeeping Director) stated that the stains were from the residents and that the floors get cleaned every day. Facility policy titled, Resident Rights Guideline (10/2023) documents in part the resident's . right to a safe, clean, comfortable and homelike environment that allows independence as possible . Facility policy titled, Housekeeping Services Policy (7/2024) documents in part, It is the policy of this facility to maintain a clean, odor free, comfortable and orderly environment in all healthcare and public areas, which meet the sanitation needs of the facility and residents' rights for a safe, clean, comfortable home-like environment . 4. The department shall routinely clean the environment of care using accepted practices to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt and hazardsFacility policy titled, Environmental Services Policy (7/2024) documents in part, Policy: To assure that the facility is constructed, equipped and maintained to carry out all service functions protecting the health and safety of the residents, personnel and the public in compliance with all applicable federal state and local regulations . 07/28/2025 10:15AM, R129 was observed in his room, awake and alert and stated that he is the president of the resident council meeting. R129 said that his main concern is the men's shower room on the C/D wing that is horrible. Residents have complained so many times about it but nothing is being done, the room smells so bad, and one of the showers is not working. The one that is working only brings out Lukewarm water, not hot or cold. On 7/28/2025 at 10:28AM, surveyor conducted an observation of the men's shower room on the C/D wing with V12 and V13 (Housekeeping staff) and noted the bathroom to be filled with strong urine smell that is very noticeable once the door is opened. Both staff members were asked to check the shower heads, the one on the left was working but the handle was broken on the right-side shower. The bathroom floor was noted to be very dirty with brownish colored materials on the floor. V12 and V13 said that the bathroom was supposed to be cleaned at least three to four times a day and it is not supposed to smell this bad.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 its policies and procedures related to the Identified Offenders Program (IOP) for 10 out of 10 residents (R37, R43, R90, R162, R163, R164, R165, R166, R167 and R168), failed to perform criminal background checks for new residents within 24 hours of admission for 4 residents (R37, R164, R166, and R168), and failed to obtain fingerprint orders within 72 hours of a hit on the preliminary criminal history for 10 out of 10 residents (R37, R43, R90, R162, R163, R164, R165, R166, R167 and R168). These failures affected 10 residents (R37, R43, R90, R162, R163, R164, R165, R166, R167 and R168) in the sample of 68 residents reviewed for abuse policies and procedures.Findings include: Facility census, dated 7/28/25, documents 158 residents residing at the facility.On 7/29/2025 at 11:08am, surveyor requested the required documentation for IOP for 5 residents (R43, R165, R166, R167, and R168). On 7/29/25 at 12:25pm, V4 (Social Services Director) and this surveyor reviewed the requested criminal background checks for R43, R165, R166, R167, and R168 as follows: R43: V4 affirmed that R43 was admitted on [DATE] and R43's CHIRP (Criminal History Information Response Process), dated 8/09/2024, has multiple hits and arrest charges of: criminal trespass to land; retail theft; burglary; armed robbery; and aggravated arson. V4 affirmed that R43 required fingerprints and R43's fingerprints were done on 9/03/2024 (almost a month after R43 was admitted to the facility. V4 stated, We (staff) are unable to find when the fingerprints were ordered. R165: V4 affirmed that R165 was admitted on [DATE] and R165's CHIRP (Criminal History Information Response Process), dated 1/08/25, has multiple hits and arrest charges of: theft; violate order of protection; knowingly damage property; retail theft; criminal trespass to land; and driving under the influence/drugs. V4 affirmed that R165 required fingerprints. V4 stated that they (staff) were unable to locate documentation confirming whether R165 was fingerprinted. R166: V4 affirmed that R166 was admitted on [DATE] and R166's CHIRP (Criminal History Information Response Process), dated 12/27/24, has multiple hits and arrest charges of: theft; retail theft; home invasion/armed/force; residential burglary; unlawful possession of weapon by felon; possession of controlled substance; domestic battery/bodily harm; violate order of protection; criminal trespass to land; criminal damage to property; and unlawful use of a weapon. V4 affirmed that R166's CHIRP was not completed within 24 hours of admission. V4 affirmed that R166 required fingerprints. V4 stated that they (staff) were unable to locate documentation confirming whether R166 was fingerprinted. R167: V4 affirmed that R167 was admitted on [DATE] and R167's CHIRP (Criminal History Information Response Process), dated 8/28/24, has multiple hits and arrest charges of: disorderly contact; battery; battery makes physical contact; domestic battery/bodily harm; telephone harassment; and assault. V4 affirmed that R167 required fingerprints. V4 stated that they (staff) were unable to locate documentation confirming whether R167 was fingerprinted. R168: V4 affirmed that R168 was admitted on [DATE] and R168's CHIRP (Criminal History Information Response Process), dated 8/26/24, has multiple hits and arrest charges of: residential burglary and burglary. V4 affirmed that R168's CHIRP was not completed within 24 hours of admission. V4 affirmed that R168 required fingerprints. V4 said, We (staff) are unable to find when the fingerprints were ordered. R168 was fingerprinted on 9/03/2025 (over a year after admission).On 7/29/25 at 12:25pm, V4 (Social Services Director) said, The IOP for the residents was being completed by the old Social Services Director who no longer works here. I'm (V4) not sure why all the IOP stuff was not done. CHIRPs are done on new admissions either before they (new admission residents) are admitted or immediately once admitted . If there is a hit on the CHIRP, fingerprints are ordered immediately. Fingerprints are done to make sure they (residents) aren't pedophiles especially since there is a school right by us (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(facility). Background checks are done on the residents to keep the other resident's safe. Certain things might have to be put in place so keep everyone safe. On 7/29/25 at 1:20pm, surveyor requested the required documentation for IOP for an additional 5 residents (R37, R90, R162, R163, and R164).On 7/30/25, V4 (Social Services Director) and this surveyor reviewed the requested criminal background checks for R37, R90, R162, R163, and R164 as follows: R37: V4 affirmed that R37 was admitted on [DATE] and R37's CHIRP (Criminal History Information Response Process), dated 2/01/23, has a hit of knowingly damaging property. V4 affirmed that R37's CHIRP was not completed within 24 hours of admission. V4 affirmed that R37 required fingerprints. V4 said, We (staff) are unable to find when the fingerprints were ordered. R37 was fingerprinted on 2/08/23 (over a month after admission). R90: V4 affirmed that R90 was admitted on [DATE] and R90's CHIRP (Criminal History Information Response Process), dated 8/8/24, has multiple hits of burglary; residential burglary; theft; deviate sexual assault and rape. V4 affirmed that R90 required fingerprints. V4 said, We (staff) are unable to find when the fingerprints were ordered. R90 was fingerprinted on 9/03/24 (almost a month after admission). R162: V4 affirmed that R162 was admitted on [DATE] and R162s CHIRP (Criminal History Information Response Process), dated 12/14/22, has multiple hits and arrest charges of: domestic battery; domestic battery/physical contact; and unlawful use of a weapon. V4 affirmed that R162 required fingerprints. V4 stated that they (staff) were unable to locate documentation confirming whether R162 was fingerprinted. R163: V4 affirmed that R163 was admitted on [DATE] and R163s CHIRP (Criminal History Information Response Process), dated 12/07/22, has multiple hits and arrest charges of: domestic battery/bodily harm. V4 affirmed that R163 required fingerprints. V4 stated that they (staff) were unable to locate documentation confirming whether R163 was fingerprinted. R164: V4 affirmed that R164 was admitted on [DATE] and R164's CHIRP (Criminal History Information Response Process), dated 10/31/22, has multiple hits and arrest charges of: retail theft; resist peace office; and possession of controlled substance. V4 affirmed that R164's CHIRP was not completed within 24 hours of admission. V4 affirmed that R164 required fingerprints. V4 stated that they (staff) were unable to locate documentation confirming whether R164 was fingerprinted. Facility policy titled, Abuse Prevention Policy, undated, documents, in part, 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. In order to do so, the facility has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff and mistreatment of residents. I. Pre-admission Screening of Potential Residents: This facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. This facility will: Request a Criminal History Background Check within 24 hours after admission of a new resident, Check for the resident's name on the Illinois Sex Offender Registration Web site: www.isp.state.il.us, Check for the resident's name on the Illinois Department of Corrections sex registrant search page. www.idoc.state.il.us. While the background or fingerprint checks, and/or Identified Offender Report and Recommendations are pending, the facility shall take all steps necessary to ensure the safety of residents. Facility policy titled, Resident Rights Guideline, dated 10/2023, documents, in part, Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under Federal law. Our facility meets and provides these rights through care and related (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	services at all times. Safe Environment: The right to a safe, clean, comfortable, and home-like environment that allows independence as possible. Freedom from Abuse, Neglect, Misappropriation of Property and Exploitation: The right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, exploitation, and misappropriation of your property by anyone.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer 1 resident (R9) with a possible serious mental disorder for Screening and Resident Review to the appropriate state-designated authority for further assessment as required. This failure affects 1 resident (R9) reviewed for pre-admission screening in the sample list of 68 residents.Findings include:R9's face sheet documents, in part, admit date : [DATE] 11:42 AM (latest return) 01/03/2019 03:40 PM (current).R9's face sheet documents diagnoses that include but are not limited to delusional disorders, psychotic disorders, anxiety disorder and major depressive disorder.R9's care plan, last revised date 5/06/25, documents, in part, Problem: Symptoms: (R9) experiences delusions related her following diagnosis: Delusional D/o (disorder), Unspecified Dementia with Behavioral Disturbance, and Other Psychotic D/o not due to substance or psychological condition.On 7/29/25 surveyor unable to locate R9's PASARR (Preadmission Screening and Annual Resident Review) in R9's EMR (electronic medical record). Surveyor requested R9's PASARR from V1 (Administrator) and V2 (Director of Nursing).On 7/29/25 at 12:25pm, V4 (Social Services Director) said, The old Social Services Director, who no longer works here, used to care for this (PASARR submissions). (R9) should have had a PASARR I done and she (R9) also has psych diagnoses that would flag for a PASARR II to be done. We (staff) are trying to find it (R9's PASARR). All residents should at least have a PASARR 1 done.On 7/30/25 surveyor received R9's Notice of PASRR Level 1 Screen Outcome, dated 7/29/2025, that documents, in part, PASRR Level 1 Determination: Refer to Level II Onsite. Evidence shows R9's PASARR I was not completed on admission.Facility policy titled, PASSAR Guideline, revised date 11/2017, documents, in part, The objective of the PASARR guideline is to ensure that individuals with mental illness and intellectual disabilities receive the care and services that they need in the most appropriate setting. The PASARR will be evaluated annually and upon any significant change for those individuals identified. PROCEDURE: 1. admission and readmission a. The facility will participate in or complete the Level I screen for all potential admissions regardless of payer source to determine if the individual meets the criterion for mental disorder (SMI/ MD), intellectual disability (ID) or related condition. b. Based upon the Level I screen, if an individual is determined to meet the above criterion, the facility will not admit an individual, the facility will refer the potential admission to the State PASARR representative for the Level II screening process. c. Upon completion of the Level II screen, the facility will review the screen recommendations and determine the facility's ability to provide the specialized services outlined. admission decision will be determined and notification to the State PASARR representative, resident and resident representative will be completed. f. Coordination of Care: 1. Upon admission, the facility will include the PASARR level II determination and evaluation report into the residents' assessment, comprehensive care plan and transitions of care plan. (See the facility comprehensive care plan and individualized assessment guidelines). ii: The facility will care plan and provide the specialized services as indicated in the level II determination. The services will be provided under the direction of the qualified personnel indicated. iii. If the facility disagrees with the specialized services and PASARR recommendations, it will document the rationale in the medical record. The facility may apply for level II reconsideration. iv. The facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the State PASARR representative: 1. The resident individualized person-centered care plan will be adjusted to reflect the identified changes evident in the signification change in status assessment and information obtained through the level II determination.

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	145798	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Nursing & Rehab Ctr	1635 East 154th Street Dolton, IL 60419

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that that prescribed medications were administered within regulatory requirements and failed to document medication administration timely for 14 of 68 residents (R3, R5, R7, R14, R23, R46, R51, R66, R76, R109, R114, R127, R140, R150) in the sample. Findings include:The (7/28/25) facility census includes 158 residents.On 7/29/25 at 8:52 am, V11's (LPN/Licensed Practical Nurse) stated that she's a new graduate (1 month ago) and assigned to 44 residents. Surveyor advised that the residents' 9am medication administration would be observed at this time V11 responded I (V11) have 4 residents left and affirmed she (V11) passed 9am medications to 40 of the assigned residents - since 8am (within 52 minutes). V11 dispensed R75's 9am medications and scheduled Amlodipine was not initially found V11 stated It's not on the cart I have to go get it from over there (referring to the facility emergency box) then continued to search the medication cart and located the medication. V11 subsequently attempted to obtain R75's blood pressure however resident requested to get dressed and go to the bathroom first. R75's blood pressure was then taken - prior to administration. A total of 22 minutes transpired during R75's medication administration observation. Considering reasonable person concept, assigned workload, and R75's medication administration observation V11 likely administered 9am medications (prior to 8am) therefore not within regulatory requirements. On 7/29/25 at 9:11am, V25 (RN/Registered Nurse) was assigned to 26 residents. Surveyor inquired about the 9am medication administration V25 stated I only have 1 left, 1 more person to give meds to. Surveyor inquired when V25 started medication administration V25 responded We (staff) start it when I (V25) came in, I got here at 7am so about 7:30 it was. Surveyor inquired about the regulatory requirements for 9am medication administration V25 replied You have to start between 8am and 10:00 for the morning shift. Surveyor inquired why seven (7) residents (R7, R14, R51, R109, R114, R127, R140) assigned to V25 were highlighted red and marked late on the EMAR (Electronic Medical Administration Record] V25 replied It needs to be completed, I (V25) just need to click it out and affirmed the highlighted residents received prescribed medications however they were not documented immediately after administration. On 7/29/25 at 9:28am, V26 (LPN) was assigned to 31 residents. Surveyor inquired about the 9am medication administration V26 affirmed that all but one (1) assigned resident (R112) who was currently receiving therapy received their medications. Surveyor inquired why five (5) additional residents (R5, R23, R46, R66, R76) assigned to V26 were highlighted green and marked due on the EMAR V26 stated I (V26) just gotta sign all of the stuff, the meds and stuff. Surveyor inquired about the regulatory requirement for medication administration V26 responded Chart it as you give. On 7/29/25 at 9:36am, V27 (RN) stated that the 9am medications were passed to all her (V27's) assigned residents. Surveyor inquired why R3 and R150 were highlighted green and marked due on the EMAR V27 responded These residents are assigned to the other Nurse and affirmed they were assigned to V26 (on the split assignment). The (10/25/14) medication administration policy states when medications are administered from a central location, such as the medication room, medications for the immediate administration time may be prepared no more than 60 minutes in advance for all residents, or per applicable state law or regulation. The individual who administers the medication dose records the administration on the resident's MAR record directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.

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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. Based on observation, interview and record review, the facility failed to assess, document, and treat 2 wounds on 1 resident reviewed for skin conditions. These failures have the potential to affect 1 resident (R106) out of a sample of 68 residents.Findings include:On 7/28/25 at 10:00am, R106 was observed in his (R106) room, sitting in the wheelchair. Surveyor observed a quarter sized open area on R106's left shin. R106's right leg was wrapped in a dressing with 2 golf ball sized areas of dried serosanguinous fluid on R106's dressing located on the back (calf) of R106's right leg. On 7/28/25 at 10:00am, R106 said, My legs always be like that. I (R106) sometimes be hitting my legs on the wheelchair.R106's face sheet documents diagnoses that include but are not limited to chronic venous hypertension (idiopathic) with ulcer of left lower extremity, left lower leg venous ulcer, peripheral vascular disease, Cellulitis of right lower limb, and type 2 diabetes mellitus with unspecified complications. R106's BIMS (Brief Interview for Mental Status) Summary Score: 11, dated 6/05/25, suggests R106's cognition is moderately impaired.On 7/28/25 at 10:02am, surveyor requested the wound care nurse.On 728/25 at 10:08am, V31 (wound care nurse/Licensed Practical Nurse/LPN) said, As of Friday (7/25/25), R106 did not have any open areas on his (R106) legs. There's no treatment for R106's legs currently because there aren't any open areas. Everything was crusted over. His (R106) legs weren't like that (open areas). R106 has chronic lymphedema of the legs. R106's right leg is wrapped per his (R106) preference. On 7/28/25 at 10:33am, while in R106's room with V32 (medical doctor) assessing R106's right and left legs, V32 stated that R106 has a left shin skin tear approximately 4 cm X 1 cm and right skin tear approximately tear 4 cm X 6.2 cm. V32 said, He (R106) might have hit it (legs) on something.R106's progress note, dated 7/29/25 at 3:12pm, per V31 (wound care nurse/Licensed Practical Nurse/LPN), documents, in part, Resident as noted with skin alterations. When resident was assessed, resident was noted with per MD (medical doctor) skin tear to right calf, and Left shin. Bright red tissue noted with moderate drainage noted to both areas. Wound MD assessed areas as well. Treatment orders were put into place. Wound MD will continue to follow resident weekly. Wound care will continue to monitor.R106's Wound Management, date identified 7/29/2025 at 7:51am, documents, in, part, right calf skin; present on admission: no; tear 4 cm X 6.2 cm 07/29/2025 07:51 AM. R106's Wound Management, date identified 7/29/2025 at 7:51am, documents, in, part, left shin skin tear; present on admission: no; 4 cm X 1 cm 07/29/2025 07:45 AM.R106's care plan, start date 7/29/2025, documents, in part, Problem: (R106) has skin tear to Right calf r/t (related to) possible trauma from extremity coming into contact with w/c (wheelchair).R106's care plan, start date 7/29/2025, documents, in part, Problem: (R106) has skin tear to Right calf r/t possible trauma from extremity coming into contact with w/c.R106's most recent MDS (Minimum Data Set), Section M, dated 6/05/25, documents, in part, Is this resident at risk of developing pressure ulcers/injuries? YES. Does this resident have one or more unhealed pressure ulcers/injuries? NO. Evidence shows that the facility was unaware of R106's skin tears.R106's Braden Scale, dated 6/29/25, documents, in part, . score: 16. which indicates R106 is at mild risk for developing pressure ulcers. Evidence shows R106 should be receiving weekly skin assessments.Facility policy titled, Pressure Ulcer and Wound Prevention/Management Program, dated 12/05/06, documents, in part, . Policy: To prevent and manage wound care through a group of health care professionals. Residents' skin will be inspected during daily bathing, dressing, showering, and incontinency care with special attention to bony prominences by C.N.A.'s (certified nursing assistants) and staff nurses. Bony prominences include: Occipital, chin, scapula, elbow, sacrum, ischium, iliac crest, trochanter, knee, malleolus, and heel. Other common areas of breakdown include lower extremities and toes. 4. Weekly skin assessments will be completed for residents who are mild and moderate (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk for breakdown. Daily skin assessments will be completed for residents who are high and severe risk for breakdown. Facility will determine where documentation of skin assessments will be completed, i.e. on the Treatment Administration Record or shower sheet by a licensed nurse.Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to have the low air loss mattress (LAL) at the correct weight settings for one resident (R13) with a chronic wound, who is also at high for developing pressure ulcers. This failure has the potential to affect 1 resident (R13), reviewed for pressure ulcer prevention interventions, in a total sample of 68 residents.Findings include:On 7/28/25 at 9:44am, R13 was observed in her (R13) room, laying on her (R13) back, on a LAL (low air loss mattress) set at 600 to 1000 pounds.R13's most recent, dated 7/07/25 at 9:45am, is documented at 187.8 pounds. R13's LAL mattress is set at minimum 412.2 pounds over the recommended weight.On 7/28/25 at 9:44am, R13 said, No, this mattress is not comfortable. I (R13) feel like I'm (R13) laying on a cement floor.R13's Face Sheet, documents medical diagnoses that include but are not limited multiple sclerosis, gastrostomy status, urinary incontinence, neuromuscular dysfunction of the bladder, and urinary tract infection. R13's BIMS (Brief Interview for Mental Status) Summary Score: 12, dated 6/16/25, suggests R13's cognition is moderately impaired.R13's Braden Observation, dated 6/10/2025, documents in part a score of 15 which indicates R13 is at mild risk for developing pressure ulcers. R13's Wound Management, dated 7/23/25, documents, in part, stage IV pressure ulcer; length 3.3cm, width 2.5cm; moderate Serous (clear, amber, thin and watery) drainage.R13's care plan, reviewed/revised date 6/17/2025, documents, in part, Problem: (R13) requires a foley catheter placement for urinary incontinence secondary to poor wound healing of sacral pressure ulcer stage 4.On 7/30/25 at 2:01pm, V31 (wound care nurse/Licensed Practical Nurse/LPN) said, The purpose of LAL (low air loss) mattresses weight setting is to know how far mattress should be so they can be. I'm (V31) not sure but let me (V31) go check the policy. They (LAL mattresses) are supposed to be set at resident's weight. I'm (V31) not sure why, but I'll (V31) find out. Been here 11 years. I'm (V31) not certified in wound care.Facility policy titled, Pressure Ulcer and Wound Prevention/Management Program, dated 12/05/06, documents, in part, Purpose: To identify residents who are at risk for pressure ulcers and skin breakdown. To prevent pressure ulcers and skin breakdown when it occurs. To provide a guideline for the appropriate nursing management of skin. Policy: To ensure a resident who has been admitted with pressure ulcers or develops pressure ulcers in-house receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing, when possible. To prevent and manage wound care through a group of health care professionals. Residents' skin will be inspected during daily bathing, dressing, showering, and incontinency care with special attention to bony prominences by C.N.A.'s (certified nursing assistants) and staff nurses. Bony prominences include: Occipital, chin, scapula, elbow, sacrum, ischium, iliac crest, trochanter, knee, malleolus, and heel. Other common areas of breakdown include lower extremities and toes. 4. Weekly skin assessments will be completed for residents who are mild and moderate risk for breakdown. Daily skin assessments will be completed for residents who are high and severe risk for breakdown. Facility will determine where documentation of skin assessments will be completed, i.e. on the Treatment Administration Record or shower sheet by a licensed nurse.Facility present manual titled (Name of Company) Low Air Loss Mattress, dated 2014, that documents, in part, 9. Turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide.'Facility policy titled, Low Air Loss Mattress Policy, revised date 1/17/2022, documents, in part, Policy: It is the policy of this facility to use Low Air Loss Mattress for pressure reduction. It is recommended for residents with stage III and IV pressure ulcers. Purpose: To provide additional pressure reduction and aid in the healing of stage III and IV pressure ulcers. Prior to use of low air low mattress, proper inflation is indicated. Motor unit weight setting may be adjusted to the weight of the resident.In Center for Medicare and Medicaid Services (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	article, dated 4/7/22 and titled Pressure Reducing Support Surfaces - Group 2 - Policy Article, documents, in part, that styles of Group 2 powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following: an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and a surface designed to reduce friction and shear, and can be placed directly on a hospital bed frame. Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review the facility failed to provide supervision, failed to implement fall prevention interventions, and/or failed to address safety hazards for five of 68 residents (R2, R139, R141, R144, R161) in the sample. Findings include: R144 is [AGE] years old and have resided at the facility since 2014, past medical history includes, but not limited to chronic obstructive pulmonary disease, unspecified dementia, type 2 diabetes, Parkinson’s disease, delusional disorder, etc. 07/28/2025 3:32 PM R144 was observed in his room at the end of the hall, awake, alert and oriented with confusion, stated he just came back from the hospital but does not know why. R144 was naked with his dirty diaper on the bed, G-tube plunger noted at the bedside table, resident's bed was unplugged from the wall, another cord not attached to anything was lying close to resident's bed. There was no call light close to resident or any floor mats noted. 07/28/2025 3:36 PM 11 (LPN) said that she is the assigned nurse for the resident, R144 has a lot of behavior and must have unplugged the bed from the wall and now V11 cannot get it back to the wall, she will get maintenance to fix it. V11 said that resident went to the hospital for altered mental status, he had a fall recently but did not go out the same day. V11 added that resident do not have a G-tube, the g-tube plunger is not supposed to be in his room, resident has a habit of picking stuff from another room and bringing it back to his room, he is currently the only resident in the room. Fall risk evaluation dated 4/3/2025 scored R144 as 11, high risk for fall. Minimum Data Set (MDS) assessment dated [DATE] indicate a BIMs score of 10 for residents’ cognitive pattern, section GG (functional status) indicated that resident requires supervision/ staff assistance for all Activities of Daily Living (ADLS). Per record review, R144 has had 3 falls this year, on 3/17/2025, resident had an unwitnessed fall in the hallway in the B wing. On 5/17/2025 resident was observed in his room on the floor at 11:30PM in a sitting position with clothes on the floor. At 0100, resident was noted in the hallway and was redirected to his room, then at 0300 the nurse aide reported that resident was bleeding, and the nurse documented a laceration to left lateral eyebrow and bruising to the left elbow. Resident was sent to the hospital for further observation. On7/20/2025 resident had a witnessed fall while ambulating in the hallway without assistive device and sustained a skin tear on the left side of forehead. R144 was again sent out to the hospital for aggressive behavior. 07/29/2025 9:35 AM, Resident was not in his room, room noted to be deserted, one pair of shoes and 3 tubs of deodorant on the dresser, there was a garbage can and an isolation bin at the entrance of the room. At 9:40AM surveyor asked staff about the resident, and she said that he was moved to another rom this morning. Resident was observed in his new room at the end of another hall. Care plan dated 7/28/2025 stated that resident is a high risk for fall related to shuffled gait, dementia, use of psychotropic medication, Parkinson, etc. Interventions include keep call light in reach, keep bed in lowest position, assure floor is free of glare, liquids, foreign objects, keep personal items within reach, floor mats x2, etc. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/30/2025 10:00 AM, surveyor asked V35 (Restorative Nurse) if R144 have a fall care plan prior to 7/28/2025 and what type of interventions were in place. V35 said that R144 has an initial fall care plan but it was updated on 7/28/2025 with additional interventions. Resident did not have a floor mat prior to the last fall, they included toileting as needed, educated resident watching the pathway, report when there is a fall, etc. V35 was unable to identify the interventions in place for R144 prior to 7/28/2025. Fall policy revised August 2008 stated in that as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. Under monitoring and follow up, #2 The staff and physician will monitor and document the individual’s response to interventions intended to reduce falling or the consequences of falling. 4. If the individual continues to fall, the staff and physician will re-evaluate the situation and consider other possible reasons for the resident falling (besides those that have already been identified). Findings include: The (7/28/25) facility census includes 158 residents. R161’s (7/26/25) care plan states resident is high risk for falls due to limited mobility, weakness, and missing limbs, interventions: bed to the lowest position, floor mats in place x2. On 7/28/25 at 10:10am, R161 affirmed “I (R161) arrived Saturday (7/26/25), I need Physical Therapy. I had this leg (right leg) amputated so I need to be fitted for the prosthesis.” R161 was lying in bed however assistive devices to turn/reposition in bed were not in place. Surveyor inquired about facility concerns R161 stated “The biggest concern is that I (R161) don’t have side rails, this table is the only thing preventing me from falling from the bed. A rail would make a big difference because that’s the only way I can move.” A floor mat was adjacent R161’s bed (near the window) however the other floor mat present was leaning against the footboard. R161’s bed was not in low position and the floor was notably wet (under the bedside table). On 7/28/25 at 10:19am, surveyor inquired about R161’s fall prevention interventions V11 (LPN/Licensed Practical Nurse) stated “Lower bed, the mat on the floor and the call light within reach.” Surveyor inquired about concerns with R161’s floor mats V11 responded “He (R161) doesn’t have a mat on this side because the tray is there” (referring to the bedside table). Surveyor inquired what was spilled on R161’s floor V11 responded “It’s wet but I can’t tell you what it is.” Surveyor inquired if R161’s bed was in the lowest position V11 replied “No, it’s not” and proceeded to lower the bed. Surveyor relayed concerns with R161’s bed (without side rails) V11 stated “That would be something I (V11) would have to communicate with someone, I would need to go to the DON (Director of Nursing) and I would ask her (DON).” On 7/30/25 at 10:05am, surveyor inquired about R161’s functional status and fall prevention interventions V35 (Restorative Nurse) stated “He (R161) requires some max assist and dependent on staff as far as moving, sitting up. He requires staff assistance with transfers, he’s missing limbs on the lower extremity. He’s missing the right leg and left ankle, foot. I have him for fall mats, bed in lowest position, call light within reach, toileting needs addressed.” Surveyor inquired if R161 was offered side rails V35 responded “He was not because we (facility) do not do side rails here. He asked when I saw him and it was the weekend, I said I would speak to administration about side rails.” Surveyor inquired if V35 spoke to administration about R161’s siderails V35 replied “No, we (staff) were busy doing other things. I could probably do a overhead trapeze if he (R161) wants to use it” (R161 was (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted 4 days prior). Surveyor inquired if it was appropriate to use only 1 floor mat when R161 was lying in bed V35 stated “They should have both been put down while he was in bed.” R2’s (7/1/25) functional assessment affirms partial/moderate assistance is required for putting on footwear. R2’s (4/5/25) care plan states resident is at risk for falls due to lower extremity weakness and unsteady balance, intervention: encourage resident not to attempt self-transfer or self-ambulation. ADL (Activities of Daily Living) care includes the following intervention: ensure proper fitting shoes are being worn. On 7/28/25 at 10:31am, R2 was observed in the dining room seated in a wheelchair. The back of R2’s shoes were folded downward, and both heels were on top of the shoes. Surveyor inquired if R2 can walk V11 (LPN) stated, “With assistance.” Surveyor inquired about concerns with R2’s shoes V11 refrained from responding and proceeded to pull the back R2’s upward then placed both feet in the shoes correctly. On 7/30/25 at 10:11am, surveyor inquired about R2’s functional status and fall prevention interventions V35 stated “He (R2) requires assistance, contact while he’s walking. He’s currently in a wheelchair now because he’s weak. He’s encouraged not to self-transfer.” Surveyor inquired if R2 requires assistance with placing shoes on V35 responded “Yes, properly making sure they’re on all the way, laced.” On 7/28/25 at 10:40am, ten (10) residents were noted to be unsupervised in the dining room (with soda/snack machines). V23 (Medical Records) subsequently entered the dining room, surveyor inquired who was supposed to be monitoring the dining room V23 (Medical Records) stated, “I’m not sure, they (facility) have a list on the front board.” Surveyor inquired if staff were present in the dining room V23 responded “No ma am.” On 7/28/25 at 12:33pm, water was noted to be dripping from the main dining room ceiling onto the floor. Surveyor inquired why the water was leaking from the ceiling V7 (Maintenance Director) stated “It’s been coming from the HVAC (Heating Ventilation Air Conditioner) it’s fixed” and affirmed “I just repaired that.” On 7/29/25 at 9:38am (the following day), a large puddle of water was observed on the main dining room floor with a bath blanket present. Water was noted to be dripping from the ceiling and a wet floor sign was near the puddle however collection containers were not in use – to prevent hazards. R141’s (11/25/24) care plan states resident is limited in his functional abilities due to left sided weakness without full range of motion to left shoulder, intervention: provide required level of assistance and support. On 7/29/25 at 1:00pm, R141 was in the dining room wearing a shoe on the left foot and a sock (with holes) on the right foot. V11 (LPN) directed R141 to go to his room for medication administration and failed to address the footwear. Surveyor inquired why R141 was not wearing both shoes V11 stated “He (R141) refuses to put the other one on” and failed to offer any assistance with ambulation and/or footwear. On 7/30/25 at 10:21am, surveyor inquired about R141’s functional status and fall prevention interventions V35 stated “He’s (R141) able to provide his own dressing assistance and uses a roller walker for ambulation but he doesn’t like to wear shoes on one of his feet but he does put on non-skid footwear.” Surveyor inquired why R141 wears only 1 shoe V35 responded “His foot is actually swollen, he just doesn’t want to, he’s very difficult to manage.” Surveyor inquired if R141 was offered different shoes (due to identified swelling) V35 replied “I’m not sure.” R139’s (5/1/25) BIMS (Brief Interview Mental Status) determined a score of 7 (severe (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive impairment). R139’s (2/3/25) care plan states resident receives limited to extensive assist with dressing, intervention: allow extra time to complete ADLS (Activities of Daily Living). On 7/29/25 at 1:26pm, R139 was observed seated in a wheelchair (in the hallway) with his pants pulled down (a pullup and both thighs were exposed). R139 was wearing a sock on the right foot however the left foot was exposed, and both feet were on the floor. V26 (LPN) was in the hallway (standing next to surveyor) during observation however failed to address concerns with R139’s privacy and/or safety until surveyor inquired about the resident. On 7/30/25 at 10:17am, surveyor inquired about R139’s functional status and fall prevention interventions V35 stated “He (R139) uses a wheelchair, he can walk with an assistive device with staff. Keep areas free of obstacles, ensure positioning, items within reach, provide toileting assistance as needed.” Surveyor inquired if R139 can dress himself V35 responded “Yes, he can put his clothes on with cueing.” Surveyor relayed concerns regarding R139 observed in a wheelchair without shoes and/or non-slip socks on V35 replied “Everyone should have on shoes unless he has on slippers.” The falls clinical protocol (revised 8/08) states as part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risk of serious consequences of falling.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to follow policy and procedure and ensure the tube feeding syringe was changed daily on 1 resident (R13) and failed to label 1 resident's (R13) tube feeding syringe with the resident's name. These failures have the potential to affect 1 resident (R1) reviewed for tube feeding management in the total sample of 68 residents. Findings include:On 7/28/25 at 9:44am, during a tour of R13's room, surveyor observed R13's tube feeding syringe hanging on a pole next to R13's bed. R13's tube feeding syringe was observed in an opened package with the date 7/25 and no without R13's name labeled on it.On 7/28/25 at 9:44am, R13 said, Darling. I'm (R13) not sure how old that (tube feeding syringe) is. If I (R13) need a new one, please toss it and by all means get me a new one.R13's Face Sheet, documents medical diagnoses that include but are not limited multiple sclerosis, gastrostomy status, urinary incontinence, neuromuscular dysfunction of the bladder, and urinary tract infection. R13's BIMS (Brief Interview for Mental Status) Summary Score: 12, dated 6/16/25, suggests R13's cognition is moderately impaired.R13's care plan, reviewed/revised date 6/11/2025, documents, in part, Problem: (R13) has nutritional needs not met by oral feeding, noted with weight loss and requires tube feeding R/T (related to) Dx (diagnosis) of MS (multiple sclerosis).R13's active physician orders, dated 7/28/2025, documents, in part, enteral bolus feed: 1 can (237 ml / 8oz per can) Jevity 1.5 BID (twice a day). To provide 474 ml total daily volume . Enteral Feeding general flush: 100 ml water (H2O) before and after each bolus feeding twice a day.On 7/30/25 at 3:49pm, V2 (Director of Nursing/DON) stated that the tube feeding syringe should be changed every 24 hours and the purpose is to prevent infection.Facility policy titled, Gastric Tube Feeding, revised date 5/17, documents, in part, . 13. Syringe for flushing is to be changed daily and labeled with resident name and date.Facility policy titled, Equipment Change Schedule Policy, dated 9/2023, documents, in part, . Piston Syringe: Daily, every 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based upon observation, interview, and record review the facility failed to ensure that respiratory equipment was labeled with a name/date and failed to contain it in a plastic bag for two of 68 residents (R127, R161) in the sample. Findings include:On 7/28/25 at 9:44am, R127's (unlabeled/undated) CPAP (Continuous Positive Airway Pressure) mask was observed in a dresser drawer and not contained in a bag. Surveyor inquired if staff keep the CPAP mask contained in a bag R127 stated No, why do I have to keep it in a bag?On 7/28/25 at 10:10am, an (unlabeled/undated) CPAP mask was observed lying directly on top of R161's mattress (not a sheet) and it was not contained in a bag. On 7/28/25 at 10:19am, surveyor inquired if R161's CPAP mask was dated and/or contained in a bag V11 (Licensed Practical Nurse) inspected R161's mask and stated, It's not in a bag and there's no date on there. The (revised August 2008) respiratory therapy prevention of infection policy states the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, among residents and staff. Infection control considerations related medication nebulizers/continuous aerosol: store the circuit in plastic bag, marked with date and resident's name, between uses. [maintaining CPAP is excluded].

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based upon observation, interview, and record review the facility failed to ensure that sufficient nursing staff were available to meet the needs for 20 of 68 dependent residents (R2, R3, R5, R7, R8, R14, R23, R36, R46, R51, R66, R76, R109, R114, R127, R139, R140, R141, R150, R161) in the sample and failed to ensure a licensed nurse had the required training/coursework to manage the facility restorative program. These failures have the potential to affect 158 residents. Findings include: Review of facility assignment sheet for 7/20/2025 on third shift documents that V39 (Certified Nursing Assistant) was assigned to A/B unit and V40 (Certified Nursing Assistant) was assigned to the C/D unit. The sheet also documents that V39 and V40 were responsible for the following activities “Answer all call lights, ADLs, POC (point of care)”. On 7/29/2025 at 12:35 AM, V2 (Director of Nursing) affirmed that on 7/20/2025 only 2 certified nursing assistants were assigned to care for the residents in the facility. V2 explained that V2 was not notified of the staffing issues until the morning, when V3 (Infection Preventionist) arrived to the facility at around 4:00 AM. V2 affirmed that no other staff were called or arrived to assist the staffing shortage. V2 affirmed that the usually staffing for the unit for 3rd shift was around 5-6 CNAs. On 7/30/2025 at 10:14 AM, V34 (MDS Nurse, Licensed Practical Nurse) stated that V34 was working on 3rd shift on 7/20/2025. V34 stated that there were only 2 CNAs scheduled for the facility during that shift. V34 stated that management was notified but no other certified nursing assistants arrived prior to the end of the shift. V34 stated that the unit that V34 was assigned to was “mainly residents that were ambulatory and didn’t need as much assistance with ADLs so with the nurses performing the work of the aides, we were able to get by”. V34 was unsure if only having 2 certified nursing assistants was a safe ratio for the facility’s care needs. V34 affirmed that the aides had to care for around 75 residents per aide. On 7/30/2025 at 12:34 PM, V39 (Certified Nursing Assistant) affirmed that V39 worked on 7/20/2025 and was the only certified nursing assistant working on the C/D unit for 3rd shift. V39 explained that there was usually 3-4 nursing assistants working on the C/D unit at night. When asked if the residents needs were able to be met, V39 replied, “It wasn’t an ideal situation”. V39 stated that V39 reported that there was only 1 nursing assistant to the staff nurses who told the management of the facility. V39 affirmed that V39 did not go to the A/B unit. On 7/30/2025 at 1:03 PM, V40 (Certified Nursing Assistant) affirmed that V40 was the only certified nursing assistant assigned to the A/B unit on 7/20/2025 on 3rd shift. V40 explained that the majority of the residents on the A/B unit are in need of assistance with activities of daily living and are incontinent. V40 recalled the night and explained that the assignment was “not doable, but I had to make it doable. All I could do was try to check and change them as best I could. No one was called in to help, it was just me. Management was aware. I couldn’t go to the C/D unit to help, we couldn’t afford to leave and help each other”. V40 affirmed that the staffing ratio for that night was unsafe and inappropriate. On 7/31/2025 at 11:43 AM, V1 (Administrator) affirmed that the facility’s census on 7/20/2025 was 153 residents. This affirms that the ratio of certified nursing assistants to residents is 1:76.5. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility provided list of incontinent residents documents in part that 57 residents in the facility are incontinent and 54 residents require assistance with activities of daily living. Facility assessment (4/4/2025) identifies that approximately 9 certified nursing assistants are needed on to meet the facility’s resident needs on night shift. Findings include: The (7/28/25) facility census includes 158 residents. On 7/28/25 at 9:44am, gnats were observed flying in R127’s room. Surveyor inquired about facility concerns R127 stated “There’s gnats all over the place. The bathroom is a s**t show with gnats in there. The showers are filthy and smell bad. The food here sucks, the food in prison is better than this place.” R127’s CPAP (Continuous Positive Airway Pressure) mask was uncontained. Surveyor inquired if staff keep the CPAP mask in a bag (to prevent infection) when not in use R127 stated “No.” On 7/28/25 at 9:56am, surveyor inquired about the gnats observed flying in the (Unit B) hallway V9 (Housekeeping) stated “I ain’t been here in a couple days so I don’t know about that.” Surveyor inquired what was hanging on the walls in R139’s room V9 responded “That’s a fly thing, I see gnats on there.” Surveyor inquired why so many gnats were flying around in R139’s room V9 replied “I see what you’re talking about. He (R139) always has food in his drawer or food in his room and I don’t know why.” V9 inspected R139’s room and dresser drawers (as requested) however there was no food present. A urinal was noted on R139’s dresser - with a tan crusty substance inside the container. Surveyor inquired about concerns with R139’s urinal V9 stated “They’re (staff) supposed to be pouring the urine out they’re (gnats) attracted to that pee. They (staff) need to get a new jug (urinal) and pour that stuff out.” On 7/28/25 at 10:01am, a pullup was observed on R140's bedroom floor and a thick clump of dirt was lying next to it. The pullup appeared to be stepped on (smeared dirt was noted on the outside). Trash was covering R140’s dresser and was also noted on the floor. Surveyor inquired what was on R140’s floor V10 (CNA/Certified Nursing Assistant) subsequently entered the room and responded, “There’s a brief right here, and a piece of paper” then picked up several items from the floor and stated “This looks like dirt ma am, he (R140) doesn’t let anybody come into his room” however nobody was in the room prior to observation. Surveyor inquired about the trash on R140’s dresser V10 replied “I see a lot of cups and pieces of paper.” Surveyor inquired about staffing concerns V10 stated “I (V10) usually work on the C/D side, they (facility) put me on B hall today because were short due to call ins I’m guessing. [The 7/28/25 schedule affirms V15 (CNA) scheduled for dayshift (7am-3:30pm) called off]. On 7/28/25 at 10:10am, R161 affirmed “I (R161) arrived Saturday (7/26/25), I need Physical Therapy. I had this leg (right leg) amputated so I need to be fitted for the prosthesis.” R161 was lying in bed however assistive devices to turn/reposition in bed were not in place. Surveyor inquired about facility concerns R61 stated “The biggest concern is that I (R161) don’t have side rails, this table is the only thing preventing me from falling from the bed. A rail would make a big difference because that’s the only way I can move.” A floor mat was adjacent R161’s bed (near the window) however the other floor mat present was leaning against the footboard. R161’s bed was not in low position and the floor was notably wet (under the bedside table). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R161’s CPAP mask was lying on the bed and uncontained. On 7/28/25 at 10:19am, surveyor inquired about R161’s fall prevention interventions V11 (LPN/Licensed Practical Nurse) stated “Lower bed, the mat on the floor and the call light within reach.” Surveyor inquired about concerns with R161’s floor mats V11 responded “He (R161) doesn’t have a mat on this side because the tray is there” (referring to the bedside table). Surveyor inquired what was spilled on R161’s floor V11 responded “It’s wet but I can’t tell you what it is.” Surveyor inquired if R161’s bed was in the lowest position V11 replied “No, it’s not” and proceeded to lower the bed. Surveyor relayed concerns with R161’s bed (without side rails) V11 stated “That would be something I (V11) would have to communicate with someone, I would need to go to the DON (Director of Nursing) and I would ask her (DON).” Surveyor inquired if R161’s CPAP mask was dated and/or contained in a bag V11 inspected the mask and stated, “It’s not in a bag and there’s no date on there.” On 7/28/25 at 10:31am, R2 was up in a wheelchair however the back of R2’s shoes were folded downward, and both heels were on top of the shoes. Surveyor inquired if R2 can walk V11 (LPN) stated, “With assistance.” Surveyor inquired about concerns with R2’s shoes V11 refrained from responding and proceeded to pull the back R2’s upward then placed both feet in the shoes correctly. On 7/28/25 at 10:40am, ten (10) residents were noted to be unsupervised in the dining room (with soda/snack machines). V23 (Medical Records) subsequently entered the dining room, surveyor inquired who was supposed to be monitoring the dining room V23 (Medical Records) stated, “I’m not sure, they (facility) have a list on the front board.” Surveyor inquired if staff were present in the dining room V23 responded “No ma am.” On 7/28/25 at 12:20pm, the (Unit B) hallway floors were notably soiled with dirt and grime. V9 (Housekeeping) was observed mopping the floor however the dirt and grime remained on the floor. On 7/28/25 at 12:22pm, R161 stated “I have not gotten my morning eye drops, the Simbrinza for my glaucoma.” On 7/28/25 at 12:31pm, surveyor inquired why R161 did not receive prescribed eye drops V11 (LPN) reviewed the EMAR (Electronic Medication Administration Record) and stated “He (R161) gets them at 9pm” however was referring to Latanoprost on the screen. Surveyor inquired if R161 has another eye drop prescribed V11 affirmed “He does not.” [R161’s (7/26/25) physician orders include Simbrinza to the left eye three times a day - scheduled for 9am administration]. On 7/28/25 at 12:50pm, R161 affirmed that he received Simbrinza “A few minutes ago” (roughly 3 hours late). On 7/28/25 at 12:33pm, water was noted to be dripping from the main dining room ceiling onto the floor. Surveyor inquired why the water was leaking from the ceiling V7 (Maintenance Director) stated “It’s been coming from the HVAC (Heating Ventilation Air Conditioner) it’s fixed” and affirmed “I just repaired that.” On 7/29/25 at 8:52 am, V11’s (LPN) stated that she’s a new graduate (1 month ago) and assigned to “44” residents. Surveyor advised that the residents’ 9am medication (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration would be observed at this time V11 responded “I (V11) have 4 residents left” and affirmed she (V11) passed 9am medications to 40 of the assigned residents - since 8am (within 52 minutes) however a total of 22 minutes transpired during R75’s medication administration observation. [Considering reasonable person concept, assigned workload, and R75’s medication administration observation V11 likely administered 9am medications prior to 8am - therefore not within regulatory requirements]. On 7/29/25 at 9:11am, V25 (RN/Registered Nurse) was assigned to “26” residents. Surveyor inquired about the 9am medication administration V25 stated “I only have 1 left, 1 more person to give meds to.” Surveyor inquired when V25 started medication administration V25 responded “We (staff) start it when I (V25) came in, I got here at 7am so about 7:30 it was.” Surveyor inquired about the regulatory requirements for 9am medication administration V25 replied “You have to start between 8am and 10:00 for the morning shift.” Surveyor inquired why seven (7) residents (R7, R14, R51, R109, R114, R127, R140) assigned to V25 were highlighted red and marked “late” on the EMAR (Electronic Medical Administration Record] V25 replied “It needs to be completed, I (V25) just need to click it out” and affirmed the highlighted residents received prescribed medications however they were not documented immediately after administration. On 7/29/25 at 9:23am, V25 (RN) left the (Unit B) medication cart (unlocked and unattended) while administering medications to R41 in the room (behind a curtain). When V25 returned to the medication cart surveyor inquired if it was locked V25 stated “No.” Surveyor inquired why the medication cart was left unlocked and unattended V25 responded “I could see it from the door” however V25 stood behind R41’s curtain during medication administration and the medication cart was in the hallway. On 7/29/25 at 9:25am, surveyor inquired about the appearance of the (Unit B) hallway floor V16 (Housekeeping) stated “It looks like dirt and paint. You gotta use the stripper, buff it, and wax.” V16 affirmed that the night shift staff is assigned to buff the floors (due to residents in the hallway during the day) however it was not getting done. On 7/29/25 at 9:28am, V26 (LPN) was assigned to “31” residents and affirmed that all but one (1) assigned resident (R112) who was currently receiving therapy received their medications. Surveyor inquired why five (5) additional residents (R5, R23, R46, R66, R76) assigned to V26 were highlighted green and marked “due” on the EMAR V26 stated “I (V26) just gotta sign all of the stuff, the meds and stuff.” Surveyor inquired about the regulatory requirement for medication administration V26 responded “Chart it as you give.” On 7/29/25 at 9:36am, V27 (Registered Nurse) stated that the 9am medications were passed to all her (V27’s) assigned residents. Surveyor inquired why R3 and R150 were highlighted green and marked “due” on the EMAR V27 responded “These residents are assigned to the other Nurse” and affirmed they were assigned to V26 (on the split assignment). On 7/29/25 at 9:38am, a large puddle of water was observed on the main dining room floor with a bath blanket present. Water was noted to be dripping from the ceiling and a wet floor sign was near the puddle however collection containers were not in use - to prevent hazards. On 7/29/25 at 12:28pm, the (Unit C) medication cart was unlocked and unattended. Surveyor inquired if the (Unit C) medication cart (assigned to V11/Licensed Practical Nurse) was locked V33 (Certified Nursing Assistant) inspected the medication cart and responded, “Oh my God.” Surveyor (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inquired again if the (Unit C) medication cart was locked V33 proceeded to lock the cart and replied, “It wasn’t.” On 7/29/25 at 12:32pm, (4 minutes later) surveyor inquired why V11’s cart was left unlocked and unattended V11 stated “That was an error that I made.” On 7/29/25 at 12:34pm, surveyor inquired about R36’s (left lower leg) lidocaine patch which was dated 7/24 (5 days prior). V11 (LPN) reviewed R36’s EMAR and stated, “He (R36) gets that at 6am, so that’s before I get here.” R36’s physician orders state – apply Lidocaine patch to right hip - not the leg. On 7/29/25 at 1:00pm, R141 was in the dining room wearing a shoe on the left foot and a sock (with holes) on the right foot. V11 (LPN) directed R141 to go to his room for medication administration and failed to address the footwear. Surveyor inquired why R141 was not wearing both shoes V11 stated “He (R141) refuses to put the other one on” and failed to offer any assistance with ambulation and/or footwear. On 7/29/25 at 1:26pm, R139 was observed seated in a wheelchair (in the hallway) with his pants pulled down (a pullup and both thighs were exposed). R139 was wearing a sock on the right foot however the left foot was exposed, and both feet were on the floor. V26 (LPN) was in the hallway (standing next to surveyor) during observation however failed to address concerns with R139’s privacy and/or safety until surveyor inquired about the resident. On 7/30/25 at 10:05am, surveyor inquired about R161’s functional status and fall prevention interventions V35 (Restorative Nurse) stated “He (R161) requires some max assist and dependent on staff as far as moving, sitting up. He requires staff assistance with transfers, he’s missing limbs on the lower extremity. He’s missing the right leg and left ankle, foot. I have him for fall mats, bed in lowest position, call light within reach, toileting needs addressed.” Surveyor inquired if R161 was offered side rails V35 responded “He was not because we (facility) do not do side rails here. He asked when I saw him and it was the weekend, I said I would speak to administration about side rails.” Surveyor inquired if V35 spoke to administration about R161’s siderails V35 replied “ No, we (staff) were busy doing other things. I could probably do a overhead trapeze if he (R161) wants to use it.” Surveyor inquired if it was appropriate to use only 1 floor mat when R161 was lying in bed V35 stated “ They should have both been put down while he was in bed.” On 7/30/25 at 10:11, surveyor inquired if R2 requires assistance with placing shoes on V35 responded “Yes, properly” making sure they’re on all the way, laced.” On 7/30/25 at 10:17am, surveyor inquired if R139 can dress himself V35 responded “Yes, he (R139) can put his clothes on with cueing.” Surveyor relayed concerns regarding R139 observed in a wheelchair without shoes and/or non-slip socks on V35 replied “Everyone should have on shoes unless he has on slippers.” On 7/30/25 at 10:21am, surveyor inquired why R141 wears only 1 shoe V35 responded “His (R141) foot is actually swole, he just doesn’t want to, he’s very difficult to manage.” Surveyor inquired if R141 was offered different shoes (due to identified swelling) V35 replied “I’m not sure.” (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Nursing & Rehab Ctr	1635 East 154th Street Dolton, IL 60419

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/30/25 at 11:00am, surveyor inquired if V35 was certified in restorative V35 stated “No, I’m working on getting enrolled today” however failed to provide (requested) documentation to affirm she was enrolled in a restorative nursing program. R8's (7/14/25) MRR (Medication Record Review) states Please take the following action described below however actions and/or instructions were excluded from the document. On 7/30/25 at 2:34pm, surveyor inquired about R8's (7/14/25) pharmacist recommendations which were excluded from the MRR V2 (Director of Nursing) stated He (pharmacist) checked off a recommendation for her (R8) but didn't send us (facility) a recommendation and presented (7/30/25) email (sent to consultant pharmacist) which states for (R8’s name) in the chart you (pharmacist) documented a pharmacy recommendation for med (medication) change but there is not recommendation attached. Can you email me (V2) this information [16 days after the recommendation was made]. The (11/2017) staffing policy states our facility provides adequate staffing to meet the needed care and services for our resident population. In addition, staffing will meet all operational activities as required. Our facility maintains adequate staffing on each shift to ensure that our resident’s needs are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services and provide supervision to CNAS and other support staff in the absence of the Administrator and/or department heads. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the residents’ comprehensive care plan. Other operational support staff are adequately staffed to ensure that resident needs are met, and that the operation of this facility is conducted. The facility periodically reviews its staffing needs using census, resident assessments, skill level required, and the Facility Assessment process to determine adequate and minimal staffing levels. When the facility drops below minimal staffing levels the facility will follow this course of action: call all line staff to augment staff shortage. Call contracted agency / temp placements to fill staff shortage with administrator approval.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure the nursing staffing information contained the required information. This failure has the potential to affect all 153 residents that reside within the facility.Facility census documents the current census is 158 residents.On 7/28/2025 at 10:25 AM, observed a staffing schedule posted in the hallway near the entrance to the lobby. The staffing schedule does not include the facility name, census, or total number/the actual hours worked by of licensed and unlicensed nursing staff directly responsible for resident care per shift. V28 (Assistant Director of Nursing) affirmed that the document is what the facility posts for the required nursing staffing posting. V28 affirmed that the document did not contain the facility name, census or any value of numbers to indicate hours worked by direct care staff.Facility policy titled Posting Direct Care Daily Staffing Numbers (Revised 8/2008) documents in part, .At the beginning of each shift facility shall post the nurse staffing data as required by state and federal regulations. The information should be in a clear and readable format. The information should be posted in a prominent place accessible to residents and visitors .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based upon interview and record review the facility failed to follow policy procedures, failed to ensure that pharmacist recommendations for medication gradual dose reduction and/or discontinuation were received, and failed to ensure that pharmacy recommendations were implemented for one of five residents (R8) reviewed for unnecessary medications, chemical restraints/psychotropic medications, and medication regimen review.Findings include:R8's (7/14/25) MRR (Medication Regimen Review) states Please take the following action described below however action and/or recommendations were excluded from the document. On 7/30/25 at 2:34pm, surveyor inquired about R8's (7/14/25) pharmacist recommendations which were excluded from the MRR V2 (Director of Nursing) stated He (pharmacist) checked off a recommendation for her (R8) but didn't send us (facility) a recommendation and presented (7/30/25) email (sent to consultant pharmacist) which states for (R8's name) in the chart you (pharmacist) documented a pharmacy recommendation for med (medication) change but there is not recommendation attached. Can you email me (V2) this information [16 days after the recommendation was made]. The (10/25/14) documentation and communication of consultant pharmacist recommendations policy states the consultant pharmacist works with the facility to establish a system whereby the consultant pharmacist observations and recommendations regarding residents' medication therapy are communicated to those with authority and/or responsibility to implement the recommendations and responded to in an appropriate and timely fashion. A record of the consultant pharmacist's observations and recommendations is made available in an easily retrievable form to nurses, physicians, and the care planning team. This should include: the consultant pharmacist documents potential or actual medication related problems, irregularities, and other medication regimen review findings appropriate for prescriber and/or nursing review. Comments and recommendations concerning medication therapy are communicated in a timely fashion.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to follow physician orders, and failed to ensure that 2 of 68 residents (R34, R161) in the sample remained free from significant medication errors.Findings include:R34's (2/16/24) physician orders include Hydralazine (Antihypertensive) 50mg (milligrams) every 8 hours; 6am, 2pm, 10pm, hold if BP (Blood Pressure) is below 100/60.On 7/29/25 at 1:12pm, V26 (Licensed Practical Nurse) obtained R34's blood pressure which was 108/70 prior to medication administration. Surveyor inquired if V26 was prepared to administer R34's (2pm) Hydralazine V26 stated, His (R34) blood pressure was 108/70, so I'm (V26) gonna hold that one and call the doctor. Surveyor responded why are you going to hold the Hydralazine? V26 replied So his (R34) blood pressure doesn't go too low. Surveyor inquired if parameters to hold R34's Hydralazine were included in the orders. V26 (subsequently) reviewed R34's EMAR (Electronic Medication Administration Record) and affirmed the Hydralazine order states, hold if BP is below 100/60. R161's (7/26/25) physician orders include Simbrinza (Lowers eye pressure) 1 drop left eye three times a day; 9am, 1pm, 9pm and Latanoprost (Lowers eye pressure) 1 drop both eyes at bedtime. On 7/28/25 at 12:22pm, R161 stated I have not gotten my morning eye drops, the Simbrinza for my glaucoma. On 7/28/25 at 12:31pm, surveyor inquired why R161 did not receive prescribed eye drops at (scheduled for 9am administration) V11 (LPN) reviewed the EMAR and stated He (R161) gets them at 9pm however was referring to Latanoprost on the screen. Surveyor inquired if R161 has another eye drop prescribed V11 affirmed He does not however at 12:50pm, R161 affirmed that he received the Simbrinza a few minutes ago (roughly 3 hours late). The (10/25/14) medication administration policy states medications are administered in accordance with written orders of the prescriber.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based upon observation, interview, and record review the facility failed to follow policy procedures and failed to ensure that 2 of 5 medication carts were locked while unattended while being reviewed for medication storage per policy and procedure. Findings include:The (7/28/25) facility census includes 158 residents.On 7/29/25 at 9:23am, V25 (Registered Nurse) left the (Unit B) medication cart (unlocked and unattended) while administering medications to R41 in the room (behind a curtain). When V25 returned to the medication cart surveyor inquired if it was locked V25 stated No. Surveyor inquired why the medication cart was left unlocked and unattended V25 responded I could see it from the door however V25 stood behind R41's curtain during medication administration and the medication cart was in the hallway. The (10/25/14) medication administration policy states during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. On 7/29/25 at 12:28pm, the (Unit C) medication cart was unlocked and unattended. Surveyor inquired if the (Unit C) medication cart (assigned to V11/Licensed Practical Nurse) was locked V33 (Certified Nursing Assistant) inspected the medication cart and responded, Oh my God. Surveyor inquired again if the (Unit C) medication cart was locked V33 proceeded to lock the cart and replied, It wasn't. On 7/29/25 at 12:32pm, (4 minutes later) surveyor inquired why V11's cart was left unlocked and unattended V11 stated That was an error that I made. The (10/25/14) storage of medications policy states medications and biologicals are stored safely, securely, and properly. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer mediations.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview and record review, the facility failed to ensure that dietary staff are properly certified for food handling. This failure has the potential to affect all 153 residents who receive food by mouth from the kitchen. Findings include:On 7/28/2025 at 9:35AM, during an initial tour of the kitchen, there were two staff members, V18 (Cook) and V17 (Cook/Dietary aide). Surveyor asked about the dietary manager and V18 said that she is not here today, she must have called off, it's only the two staff for the shift. 07/28/2025 11:25AM, during a second observation of the kitchen, V14 (Dietary Manager) was in the kitchen, stated that she just came in. There were two other staff members in the kitchen V19 and V20 (Dietary aides). V14 was asked why there was only two staff at the beginning of the shift, and she said that there was a call off and she called these two staff to come in. V14 added that she normally schedules 3 aides and one cook including herself on each shift.07/29/2025 9:05AM, during an observation in the kitchen, noted V18 (Dietary aide/cook) preparing garlic mashed potatoes, stated that she is helping the cook. V14 (Dietary manger said that she has 3 aides and 1 cook on schedule today, surveyor inquired about cook certification for V18 and V14 stated that V19 is cooking under her license. Surveyor requested the food handling certificates for all the dietary staff, V14 presented a list of 9 staff members including herself. V14 also presented an active food manager license for herself and 3 food handling certificates for three dietary aides. The cook and the dietary aide/cook who were the only staff in the kitchen when the survey team entered do not have food handling certificates. Out of the 9 dietary staff only 3 have a current food handling certificate. On 728/2025 V14 (dietary manager) presented some food handling certificates for the dietary staff. Two of the certificates for V21 and V22 (Dietary staff) does not have an expiration date, V14 later presented a new certificate for the two staff dated 7/28/2025, surveyor pointed out to V14 that there are still about 4 staff members with no certificate, including the two staff in the kitchen upon entrance. 7/29/2025 at3:00PM V14 brought 3 additional food handling certificates dated 7/29/2025 for V17 (Cook), V18 (Cook/dietary aide) and V42 (dietary aide). 7/30/2025 at 9:00AM, V14 brought one more dated 7/30/2025 for V20 (dietary aide).V14 was asked why the dietary staff does not have food handling certificates and she said that she does not know.Job description for the position of a cook and dietary aides (undated) states in part: the primary purpose of this position is to ensure that safe food handling procedures are being consistently maintained, maintain all federal, state, and local nutritional/dietary regulations.Under qualifications and essential requirements, the description states that the cook must possess a sanitation certificate.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare and handle food in a manner that prevents food borne illness by failing to ensure that garbage is properly disposed, failed to date opened cooking seasonings, failed to remove a scoop from a flour bin, failed to allow cooking equipment air dry before use, failed to ensure that the ice machine was kept clean and failed follow proper hand hygiene protocol during food preparation. These failures have the potential to cause food borne illness to 153 residents at the facility that receives oral diet from the kitchenFacilityFindings include:On 7/28/2025 at 9:35AM, during an initial tour of the kitchen, there were two staff members, V18 (Cook) and V17 (Cook/Dietary aide). Surveyor noted three bags of garbage that are full and in the middle of the floor close to where the V17 (Cook) was preparing some food. Surveyor noted one large container of paprika seasoning, onion powder, garlic powder and Italian seasoning on the shelf that were open with no open dates. Surveyor also observed one container of flour in the kitchen with lid but have a scoop left inside. This observation was presented to V17 and V18 (Dietary aide/cook). V17 said that she does not know who left the scoop inside, probably the previous shift, and V18 came and removed the scoop from the bin. The ice machine in the employee break room was noted with lots of dirt on top, and debris all over the machine.07/28/2025 11:25AM, during a second observation of the kitchen, V17 (Cook) was observed preparing pureed diet for residents. V17 finished with the sweet peas, washed the food processor, and did not let it air dry. V17 proceeded to use the same blender with water dripping from it to prepare the pureed meat. When presented with this observation, V17 said that she was supposed to let it dry but because the surveyor wanted to see the next pureed food that's why she did not let it dry.V14 (Dietary Manager) who is now present said to 18, Even if the president is standing here, you are supposed to let the food processor air dry before using it. Surveyor also presented the ice machine to V14 (Dietary manager), and she said that the housekeepers are supposed to clean the ice machine, she will let them know.The surveyor also observed V19 (Dietary aide) who was preparing sandwiches for residents. V19 touches the surfaces with her gloved hands and continues to grab the slices of bread and eat with same gloves without changing her gloves. V14 (Dietary manager) whispered something to V19 who proceeded to remove her gloves ad donned another pair of gloves without performing any type of hand hygiene, then continues to prepare the sandwiches. V19 switched her gloved three more times while preparing the sandwiches but did not wash her hands or use any hand sanitizer in between glove changes.07/29/2025 9:05AM, during an observation in the kitchen, noted V18 (Dietary aide/cook) preparing garlic mashed potatoes, stated that she is helping the cook. V14 (Dietary manger said that she has 3 aides and 1 cook on schedule today, surveyor inquired about cook certification for V18 and V14 stated that V19 is cooking under her license.07/29/2025 9:20AM, surveyor observed two staff V21 and V22 (Dietary aides) preparing desert, V21 was observed wiping the table with his gloved hand and used the same hand to divide and grab the pieces of cakes before putting them in a plastic bag. Surveyor asked V14 (Dietary manager) if they make use of spatula in the kitchen and she said yes, went and brought a spatula and handed it to V21. V21 used the spatula to divide the cakes and continued to grab them with the same gloved ands without changing his gloves or performing any type of hand hygiene.Hand washing/hand hygiene policy dated March 2024 states in part: it is the policy of the facility to assure staff practice recognized handwashing/hand hygiene procedures as a primary means to prevent the spread of infections among residents, personnel, and visitors. Alcohol based hand rubs (ABHR) can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids.Under policy specifications #4 states: when hands are not visible soiled, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	employees may use an alcohol-based hand rub containing at least 60% alcohol in all the following situations:C. before donning gloves. H. before and after putting on and upon removal of PPE including gloves.6. The use of gloves does not replace compliance with hand washing/hand hygiene procedures.

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F 0868 Level of Harm - Potential for minimal harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure that the medical director participated in the facility's QAA/QAPI programming. This failure has the potential to affect all 158 residents that reside within the facility. Facility census documents an active census of 158 residents. Facility QAA committee meeting sign-in sheets (4/30/2025, 7/17/2025) do not document any signature from the facility's medical director affirming the medical director's attendance. On 7/30/2025 at 10:04 AM, QAA meeting minutes were reviewed with V1 (Administrator) and V1 affirmed that the facility's medical director was not at the QAA meetings. V1 affirmed that the medical director is required to be at the QAA meetings. On 7/30/2025 at 11:55 AM, V38 (Nurse Consultant) affirmed that V38 is a member of the governing body of the facility and sometimes attends QAA meetings. QAA meeting minutes were reviewed with V38 and V38 affirmed there was no signature from the medical director. V38 affirmed that it is a requirement that the medical director attend and be involved with the QAA/QAPI programming. V38 stated that the purpose of QAPI is to evaluate/analyze facility systems and try to improve how the facility gives care. Facility policy titled, QAPI Program Overview/Preamble (Undated) documents in part, .All consumers, staff, facility services, and departments will participate in system and process improvement analysis, evaluation and modification .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review, the facility failed to follow their water management policy by 1. Failed to implement the facility's water management program by failing to educate team members on the principles of an effective water management program, 2. failed to maintain documentation that describes the facility's water system, 3. failed to annually conduct a risk assessment and identify control points to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the water system, 4. failed to ensure control measures were applied to address potential hazards at each control point, 5. failed to evaluate the effectiveness of the water management program annually using infection control surveillance data, water quality data, and rounding data, 6. failed to report relevant information to the QAPI (Quality Assurance and Performance Improvement) committee, and 7. failed to document all activities related to the water management program and maintain the documentation for a minimum of three years. This failure affects all 158 residents residing in the facility.Findings include:On 07/30/2025 at 12:40 PM, V7 Maintenance Director was inquired of completing the water testing per the facility policy. V7 said, We don't test no water here. The city has come and checked the water before. The previous administrator has handled all the paperwork since I've been here three years. On 07/30/2025 at 2:30 PM, V36 Assistant Administrator was inquired of completing the water testing per the facility policy. V36 said, We don't have any documents for water testing.V7 provided a blank environmental assessment of water systems to this surveyor for review. V7 and V36 were unable to provide any documentation on implementation of the risk assessment.The 03/2023 Water Management Policy states in part: Policy: It is the policy of this facility to establish water management plans for reducing the risk of Legionellosis and other opportunistic pathogens (e.g., ASHRAE, CDC, EPA). Policy Explanation and Compliance Guidelines:1. A water management team has been established to develop and implement the facility's water management program, including facility leadership, the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing.a. Team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team member's role.b. The water management team has access to water treatment professionals, environmental health specialists, and state/local health officials.2. The maintenance director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder.3. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic water-borne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements:a. Premise plumbing: This includes water system components as described in the documentation of the facility's water system.b. Clinical equipment: This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration.c. At-risk population: This facility's entire population is at risk. High risk areas shall be identified through the risk assessment process. Supporting documentation of any areas or resident population that exhibit greater risk than the general population shall be kept in the water management program binder.4. Data to be used for completing the risk assessment may include, but are not limited to:a. Water system schematic/descriptionb. Legionella environmental assessmentc. Resident infection control surveillance data (i.e. culture results)d. Environmental culture resultse. Rounding observation dataf. Water temperature logsg. Water quality reports from drinking water provider (i.e. municipality, water company)h. Community infection control surveillance data (i.e. health department data)5. Based on the risk assessment, control points will be identified. The list of identified points shall be kept in the water (continued on next page)

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	07/31/2025

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.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	management program binder.6. Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical control points temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan.7. Testing protocols and control limits will be established for each control measure.a. Individuals responsible for testing or visual inspections will document findings.b. When control limits are not maintained, corrective actions will be taken and documented accordingly.c. Protocols and corrective actions will reflect current industry guidelines (i.e., ASHRAE, OSHA, CDC, EPA).8. The water management team shall regularly verify that the water management program is being implemented as designed. 9. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data, and rounding data shall be utilized to validate effectiveness.12. The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program, and as needed such as when any of the follow events occur: a. Data review shows control measures are persistently outside of control limits, b. A major maintenance or water service change occurs (including replacing tanks, pumps, heat exchangers, distribution piping, or water service disruption from the supplier to the building), c. One or more cases of disease are thought to be associated with the facility's systems, or d. Changes occur in applicable laws, regulations, standards, or guidelines.14. Documentation of all the activities related to the water management program shall be maintained with the water management program binder for a minimum of three years.15. The water management team shall report relevant information to the QAPI committee.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based upon observation, interview, and record review the facility failed to maintain an effective pest control program and failed to ensure the facility remained free from flying insects. This affected two residents (R127, R139). These failures have the potential to affect 158 residents.Findings include:The (7/28/25) facility census includes 158 residents.On 7/28/25 at 9:40am, gnats were observed flying in the (Unit B) hallway. On 7/28/25 at 9:44am, gnats were observed flying in R127's room and a can of insect repellent was lying on the bed. Surveyor inquired about facility concerns R127 stated There's gnats all over the place. The bathroom is a s**t show with gnats in there and affirmed the door is kept shut to prevent gnats from entering the room. Surveyor inspected R127's room however food and/or trash were not present. On 7/28/25 at 9:54am, a total of nine (9) fly traps were observed hanging on the walls in R139's room, multiple flies and/or gnats were noted on each fly trap. On 7/28/25 at 9:56am, surveyor inquired about the gnats observed flying in the (Unit B) hallway V9 (Housekeeping) stated I ain't been here in a couple days so I don't know about that. Surveyor inquired what was hanging on the walls in R139's room V9 responded That's a fly thing, I see gnats on there. Surveyor inquired why so many gnats were flying around in R139's room V9 replied I see what you're talking about. He (R139) always has food in his drawer or food in his room and I don't know why. V9 inspected R139's room and dresser drawers (as requested) however there was no food present. A urinal was noted on R139's dresser - with a tan crusty substance inside the container. Surveyor inquired about concerns with R139's urinal V9 stated They're (staff) supposed to be pouring the urine out they're (gnats) attracted to that pee. They (staff) need to get a new jug (urinal) and pour that stuff out. On 7/28/25, surveyor requested the facility pest control binder however only one (1) pest control service inspection report dated 3/17/25 was received.On 7/30/25 a10:49am, surveyor inquired about pest control services provided by the facility V7 (Maintenance Director) stated, A company comes when we (facility) call them (pest control company) if there's an issue, and they (pest control company) come out frequently as well. Surveyor inquired how frequent the pest control company comes to the facility V7 responded Every 3 months. Surveyor inquired if pest control came to the facility to inspect and/or apply treatments since 3/17/25 (4.5 months ago). V7 replied No however subsequently provided a pest control service inspection report dated 7/26/25. The (1/1/23) pest control policy states the facility maintains an effective pest control program to remain free of pests. Facility wide pest control strategies are developed emphasizing kitchens, dining rooms, laundries, central supply, garbage storage areas, resident areas, and other areas prone to pest infestations. A contract with a pest control company may be elected to assure regular inspection and application of chemical pesticides.