STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146080	A. Building B. Wing	03/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Care Center	400 West Grant Street Macomb, IL 61455

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32875 Based on interview and record review the facility failed to correctly enter and follow a physician's order for one resident of three residents (R1) reviewed for steroid injections in the sample of three. Findings include: The Administering Medication policy dated 10/15/23 documents Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Procedure: 3. Medications shall be administered according to physician's written/verbal orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. 20. Should a dosage seem excessive considering the resident's age and medical condition, or a medication order seems to be unrelated to the resident's current diagnosis or medical condition, the person preparing/administering the medication shall contact the resident's attending physician or the facility's medical director for further instructions. The Medication Errors policy dated 11/5/19 documents Purpose; It is the policy of this Facility to establish and follow a uniform process of medication error management, in regards to reporting medication errors and ensuring accurate and appropriate use of medications. Policy interpretation and implementation: The nurse that has noted the Med Error will contact the Director of Nursing, Physician, Resident/POA (Power of Attorney)/Guardian and the Facility Pharmacy. This Facility feels that reporting of errors or potential errors will help us to identify and remediate problem processes or to identify areas of needed staff or individual staff education. Medication Errors include A. Wrong person B. Wrong drug C. Wrong dosing D. Wrong time E. Wrong route. The Registered Nurse Job Description (not dated) documents Responsibility for complying with facility policies and procedures and making recommendations for revisions. Receives and transcribes written, verbal and telephone orders to the chart, MAR (Medication Administration Record), TAR (Treatment Administration Record), etc. (etcetera), and assures execution of same. Responsible for interpretation and execution of physician's orders and calling physicians as indicated. Is responsible for administering and documenting medications according to the physician's order, pharmacy policy, plan of care. Review medication cards for completeness of information, accuracy in the transcription of the physician's order, and adherence to stop orders. Is responsible for competent administration of care and treatments according to physician orders and facility policy. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Face Sheet documents R1 is a [AGE] year-old male admitted to the facility on [DATE] with the diagnoses which included Other Pulmonary Embolism without Acute Cor Pulmonale, Coronary Artery Dissection, Depression, Cerebral Vascular Disease, Essential (Primary) Hypertension, Hyperlipidemia, Type 2 Diabetes Mellitus without Complications, Osteoarthritis, Generalized Anxiety Disorder, and Other Chronic Pain. R1's Medication Administration Record dated 2/1/25 - 2/28/25 documents Kenalog 40 Injection Suspension (Triamcinolone Acetonide) Inject 1 (one) mg (milligram)/ml (milliliter) intramuscularly as needed for Pain - Severe related to Unspecified Osteoarthritis, Unspecified Site to shoulder joint administered by MD (Medical Doctor) during rounds intraarticular. Start date 2/25/25 discontinued 2/27/25. (this order was not given) R1's Physicians Order dated 2/27/25 at 7:42 PM, documents Kenalog-40 Injection Suspension 40 MG/ML (Triamcinolone Acetonide) 40 mg/ml intra-articular Monthly every 1 month(s) starting on the 4th for 28 day(s) for Pain related to Other Chronic Pain to Be Administered by (V7/Nurse Practitioner-NP). R1's Medication Administration Record dated 3/1/25 - 3/31/25 documents Kenalog 40 Injection Suspension 40 MG/ML (Triamcinolone Acetonide) 40 mg/ml intra-articular Monthly every 1 month(s) starting on the 4th for 28 day(s) for Pain related to Other Chronic Pain to Be Administered by (V7/NP) Start date 3/4/25 Discontinued 3/4/25. This was signed as given by V3/Registered Nurse-RN on 3/4/25. R1's Nursing Note written by V7/NP dated 3/4/25 at 2:16 PM, documents (R1) is seen in his room today. He is resting in bed following breakfast and reports his chronic shoulder pain. Nursing staff report there has been no medication received at the facility as previously ordered to complete the steroid injection to (R1's) left shoulder. Upon further inquiry, nursing staff report there was an issue with the way in which the medication was ordered thus why it was not received. Nursing staff previously entered the order as monthly dosing, and (R1) should actually only receive a steroid injection every three months as needed. Orders have been clarified to indicate this and confirm it is an intra-articular injection versus IM (intramuscular) as the previous nurse entered it. R1's Nursing Note written by V7/NP dated 3/11/25 at 1:06 PM, documents (R1) is seen in the dining room today. (V8/Medical Director) has ordered fentanyl patches to assist with his pain. (R1) reports ongoing discomfort related to his chronic shoulder pain. We may need to reorder the Kenalog and lidocaine for the intra-articular shoulder injection for his left shoulder as the medication was given to (R1) in IM form by nursing staff. Staff report the verbal order initially entered was inadvertently entered as an IM injection. On 3/21/25 at 10:27 AM, V5 RN stated I was working when (V7/NP) came in to give a steroid injection to (R1). The medication couldn't be found. I called the pharmacy and was told that it had been delivered and signed for by (V3/RN). I asked (V3) if she knew anything about where the medication was and (V3) said that she gave it. I said we can't give a steroid because they are intra-articular. (V3) said that she gave it intramuscular. On 3/21/25 at 1:04 PM, V2/Director of Nursing/DON stated It was told to me the order read IM (intramuscular) so (V3/RN) gave it. (V6/RN) wrote the order. (R1) got the injection for pain in the shoulder. It would not be quite as effective as if given in the joint. (V7/NP) said it would be a couple of weeks before it could be given again because it could not be given back-to-back. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/21/25 at 2:22 PM, V9/Pharmacist stated The last order we got was on 3/1/25. It said to give intra-articular. The medication was delivered on 3/4/24 and signed for by (V3/RN). According to this order the medication should not have been given intramuscularly. On 3/21/25 at 2:25 PM, V2/DON stated I found the order did say it was to be given intra-articular. (V3/RN) gave it on 3/4/25 IM so that is a med error. On 3/21/25 at 2:37 PM, V7/NP stated (R1) had shoulder pain and was to have Kenalog injected in his shoulder joint. I think that V8/Medical Director was at the facility doing rounds and (V6/RN) was with him. (V8) said to order Kenalog intra-articular for (R1), and (V8) would give the injection. When (V6) put the order in (V6) put it in as IM instead of intra-articular. Then another nurse got the medication in and administered the medication IM. I went to the facility to give the injection and could not find the medication. I was told later that (V3/RN) gave the injection IM. I was not thrilled that it happened. On 3/22/25 at 2:36 AM, V3/RN stated I was working the night shift and (R1's) pain medication came in from pharmacy. On the MAR (Medication Administration Record) it said to give intramuscular. I did not click on the rounds additional comments to see that it was to be given by the doctor. It's not like I can call someone at 1:00 AM in the morning to check on an order. The next morning, I told (V6/RN) that I had given (R1) his injection IM. (V6) said that it was not to be given that way. On 3/21/25 at 5:15 PM, V8/Medical Director stated The injection was supposed to be intra-articular but was given by a nurse IM. It would not have been as effective. On 3/22/25 at 9:37 AM, V2/DON stated I did not catch that one order said 1 mg/ml and the other order said 40 mg/ml. It should have been the 40 mg/ml. The order that said IM was the wrong dose and wrong route. On 3/22/25 at 9:43 AM, V6/RN stated (V7/NP) gave me a verbal order to put Kenalog in as intra-articular but that was not an option in the computer, so I put the order in as IM with instructions for (V7) to give the injection. The pharmacy did not send the order because I had put it in as PRN (as needed). The pharmacy said it could not be entered that way and also told me how to put the order in so it would show as intra-articular.