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	04/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32875 Based on interview and record review the facility failed to notify family, physician, and Illinois Department of Public Health/IDPH of an injury for one of three residents (R1) reviewed for quality of care in the sample of three. Findings include: The Accident and Incident Investigation policy dated 4/3/24 documents To ensure all accidents, incidents and allegations of abuse involving residents, visitors, or employees are investigated and reported to the facility administration. Procedure 4. The assigned nurse or nursing supervisor shall complete an assessment and provide medical interventions as warranted. 5. Reporting of incident, accident and abuse to state and federal agencies shall be in compliance in accordance with agency guidelines. 7. The assigned nurse or nursing supervisor shall: b. As determined notify the attending physician or medical director of the occurrence. c. Follow the physician orders as instructions for rendering care. f. Date and time the physician/responsible party notification. The Reporting policy dated 11/6/24 documents Policy: Incident report requirements Policy Explanation and Compliance Guidelines: Incidents and Accidents B) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, serious means any incident or accident that causes physical harm to a resident. C) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Let's take a look at the changes: IDPH has (finally) clarified the nature of the incident that requires reporting. Serious incidents only, with serious defined as having caused physical harm or injury to the resident. R1's Nursing Note written by V8/Licensed Practical Nurse/LPN dated 3/16/25 at 9:35 AM documents Observed (R1) in (high back wheelchair) with water pitcher tipped over on lap. (R1) stating that it was burning her. Water pitcher had hot chocolate in it. (R1) taken to room and skin assessment was complete. Writer (V8) noted red area to left hip. Area not raised or blistered at this time. (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Nursing Note written by V2/Director of Nursing/DON dated 3/17/25 at 9:54 AM documents Red areas with slight blistering noted to (R1's) left waist area and left upper thigh area. V11/R1's Primary Care Physician/PCP was notified of R1's blistering and Silvadene or alternate cream was requested to apply to R1. R1's Nursing Note written by V2/DON dated 3/17/25 at 10:27 AM documents that V5/R1's Power of Attorney/POA was notified of the blistering areas. On 4/18/25 at 10:40 AM, V2/DON stated I was off and when I came in on Monday (3/17/25), I was told that (R1) spilled hot chocolate in her lap (3/16/25). I did an assessment and found there were four areas, three were pink and one had blisters. I then called (V5/R1's POA), (V11/R1's PCP) and talked to hospice. They did not know about the burn until I called them, and no treatment had been ordered. (V8/LPN) said that she had called (V5) and (V11) but there was no documentation that she did. Anytime a resident has an accident notification should be done immediately. On 4/18/25 at 11:23 AM, V5/R1's POA stated (R1) was burned on 3/16/25 by spilling hot chocolate on herself. I was not notified by the facility until 3/17/25. On 4/18/25 at 2:04 PM, V11/R1's PCP stated that he was not notified that R1 had gotten burnt until the next day. He thought that either him or the hospice doctor should have been notified immediately so they could have made the decision on what to do and how to treat R1. On 4/18/25 at 2:25 PM, V1/Administrator stated that R1 had asked for hot chocolate. The hot chocolate was made, and V14/Cook sat it on the table in front of R1. R1 pulled the drink off the table, and it fell on R1's leg. V8/LPN called V1 and said that the area was red. The area was found to have blistered the next day. That is when V2/DON called V11/R1's PCP, Hospice, and V5/R1's POA. On 4/19/25 at 1:05 PM, V1/Administrator stated that R1's burn accident was not reported to IDPH. After the burn blistered and medication was needed V1 asked Corporate if the accident needed to be reported and V1 was told No.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	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** 32875 Based on record review and interview, the facility failed to check the temperature of a hot beverage before serving and failed to assist and supervise a resident dependent with eating for one of three residents (R1) reviewed for quality of care in the sample of three. These failures resulted in R1 spilling hot chocolate on herself and sustaining a second degree burn on her left hip/thigh causing R1 pain. Findings include: The Safety and Supervision of Residents policy dated 11/5/19 documents Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Facility-Oriented Approach to Safety 1. Our facility-oriented approach to safety addresses risks for groups of residents. 4. Employees shall be trained and in-serviced on potential accident hazards and how to identify and report accident hazards and try to prevent avoidable accidents. Resident-Oriented Approach to Safety 1. Our resident-oriented approach to safety addresses safety and accident hazards for individual residents 2. Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS (Minimum Data Set assessment). Systems Approach to Safety 2. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment. Resident Risk and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include h. Water Temperatures. The Serving Food policy dated 11/5/19 documents Food shall be prepared and served in a manner that meets the individual needs of each resident. Policy interpretation and implementation 2. Residents Requiring Full Assistance c. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. 3. Dining Room Residents: c. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity. R1's electronic Medical Record documents R1 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Unspecified Sequelae of Cerebral Infarction, Schizophrenia, Bipolar Disorder, Other Disorders of Physiological Development, Unspecified Focal Traumatic Brain Injury without Loss of Consciousness, Sequela, Heart Failure, Other Pulmonary Embolism without Acute or Cor Pulmonale, Pulmonary Hypertension, and Muscle Weakness (generalized). R1 was admitted to Hospice Care on 12/19/24 due to terminal diagnosis Unspecified Sequelae of Cerebral Infarction. R1's Minimum Data Set (MDS) assessment dated [DATE] documents R1 had a Brief Interview for Mental Status/BIMS of 4 (severe cognitive impairment). R1 is Dependent on staff for eating. Helper does All of the effort. Resident does none of the effort to complete the activity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's current Care Plan documents R1 is dependent on staff for meeting emotional, intellectual, physical, and social needs related to Schizophrenia, Traumatic Brain Injury, Bipolar Disorder, Developmental Delay, Cognitive Deficits. Date Initiated 5/20/24. R1 has self-care deficit and needs supervision and/or assist to complete quality care and or poorly motivated to complete activities of daily living. Related to poor motivation, poor regard for personal hygiene, and impaired mobility. Interventions: Assist with hands on feeding if R1 is unable or unwilling to complete the task. Date Initiated 5/20/24. R1 has risk factors that require monitoring and intervention to reduce potential for self-injury. R1 will follow safety suggestions and limitations with supervision and verbal reminders for better control of risk factors. Intervention: Remind of safety precautions and limitations as necessary. Date Initiated 5/20/24. Interventions: R1 will have all drinks covered with a lid. Date initiated 3/17/25. R1 has reddened area from spilled hot chocolate noted to left hip with blistering. R1 to be served tepid, not hot drinks. Date Initiated 3/17/25. R1 currently has an infection due to wound infection of left hip. Date Initiated 3/28/25. R1's current diet is Regular, Dysphasia mechanical texture, regular thin liquids. Interventions: I (R1) will be fed by staff since I am unable to feed myself. Date Initiated 2/25/25. The Hospice Plan of Care signed by V10/Hospice Nurse dated 3/12/25 at 8:20 AM documents Interventions: Feed (R1) if visit is during a meal. Goals: Absence of injury, as evidenced by safe environment maintained to accommodate neurological deficits. (R1) will maintain a pain score of 4 (four) or less, per patient/family preference, on a scale of 0 (zero)-10. R1's Nursing Note written by V8/Licensed Practical Nurse/LPN dated 3/16/25 at 9:35 AM documents Observed (R1) in (high back wheelchair) with water pitcher tipped over on lap. (R1) stating that it was burning her. Water pitcher had hot chocolate in it. (R1) taken to room and skin assessment was complete. Writer (V8) noted red area to left hip. Area not raised or blistered at this time. The Accident statement of V14/Cook taken by V15/Dietary Manager not dated documents that on Sunday 3/16/25 a CNA/Certified Nursing Assistant requested hot chocolate for R1. V14 asked the nurse if it was OK, and the nurse said yes. V14 made the hot chocolate, put it in a cup, and put the lid on it. V14 set the drink on the counter but the CNA was no longer there so V14 took the drink to (R1) and set it on the table. R1's Nursing Note written by V2/Director of Nursing dated 3/17/25 at 9:54 AM documents Red areas with slight blistering noted to (R1's) left waist area and left upper thigh area. V11/R1's Primary Care Physician was notified of R1's blistering and Silvadene or alternate cream was requested to apply to R1. The Weekly Wound Log dated 3/17/25 documents there were four burn wounds to R1's left hip from spilled hot chocolate on 3/16/25. The wounds measured length 2.5 cm (centimeters) by width 0.5 cm, length 4.0 cm by width 3.0 cm, length 2.0 cm by width 1.0 cm, and length 15 cm by 3 cm. Pain was documented as slight discomfort. R1's Nursing Note written by V3/LPN dated 3/17/25 at 2:14 PM documents that V10/Hospice Nurse assessed R1, and new orders were given by V20/Hospice Physician for Silvadene two times a day to the blistered area on R1's left hip for seven days. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Hospice Certification of Terminal Illness signed by V20/Hospice Physician dated 3/17/25 at 3:48 PM documents (R1) is chair bound, and tends to lean forward, putting herself off balance. Speech is limited to a vocabulary of 6 (six) or less words in a conversation. Staff assist (R1) to eat, as she is unable to manage utensils. (R1) is totally dependent for bed mobility, dressing, grooming, toileting, eating, and transfers. The Hospice Visit Note signed by V10/Hospice Nurse dated 3/24/25 at 9:43 AM documents R1 has burns to left hip/thigh causing pain Soreness, Tender and pain is an active problem. Facility nurse called and stated that she believed that (R1's) burns were getting infected. (V10) completed PRN (as needed) visit. Burn areas look to be healing. Spoke with (V20/Hospice Physician) who gave orders to continue Silvadene cream 1% (percent) BID (twice a day) for 7 (seven) days. Cover area with (dressing) and secure with tape. RN (Registered Nurse) also ordered Norco 5/325 (milligrams) give one tab every 4 (four) hours PRN for pain. Discussed with facility nurse (V3/LPN) about giving Norco before dressing changes due to (R1) having pain during dressing change. R1's Medication Administration Record/MAR dated 3/1/25 - 3/31/25 documents Hydrocodone-Acetaminophen Oral Tablet 5-325 mg (milligrams) to give one tablet by mouth every four hours as needed for pain related to burn on left hip/thigh. Start date 3/24/25. R1's Nursing Note written by V18/Registered Nurse/RN dated 3/24/25 at 12:23 AM documents (R1) has extensive burn to right hip. Order to clean with wound cleanser and apply Silvadene and cover. Areas are red and blistered with open areas covered in slough. R1's Nursing Note written by V3/LPN dated 3/24/25 at 4:13 PM documents that V10/Hospice RN was in to see R1. V20/Hospice Physician gave a new order to continue Silvadene to the burn on R1's left hip/thigh, cover with (dressing) and secure with tape twice a day for seven days. Give Norco 5-325 mg one tab by mouth every four hours as needed for pain related to R1's burn. The Hospice Skilled Visit Note signed by V10/Hospice Nurse dated 3/25/25 at 11:45 AM documents R1's wound is 18 cm (centimeters) by 9 cm, slough in wound bed with small amount of Serosanguinous drainage and mild odor. Visit Plan: Contacted doctor to obtain new order for antibiotic. R1's Nursing Note written by V8/LPN dated 3/25/25 at 12:04 PM documents that V10/Hospice Nurse was at the facility today to see R1. New order received for Clindamycin 300 mg twice a day for seven days for left hip wounds. R1's Nursing Note written by V18/RN dated 3/26/25 at 12:30 AM documents that R1 continues to have extensive burns to her left hip and buttocks. All areas are opaque and covered in slough with small black areas scattered throughout. V18 faxed a request to hospice requesting to change from Silvadene to Medi honey. R1's Dietary Note written by V21/Registered Dietician dated 3/31/25 at 8:28 AM documents that during an on-site visit on 3/31 V21 was notified that R1 had a skin issue being treated that was caused by a hot liquid spillage. V21 reviewed R1's diet due to R1's burn and weight loss. V21 recommended that all drinks are to have a lid. V21 noted poor intakes. (R1) needs supervision at meals. R1's Medical Record does not include a hot liquid risk assessment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Medication Administration Record dated 3/1/25 - 3/31/25 documents Silvadene External Cream 1% (percent) (silver Sulfadiazine) Apply to left hip affected area topically every shift for blistered area. Start date 3/19/25. R1's Treatment Administration Record dated 3/1/25 - 3/31/25 documents Apply Silvadene cream BID (twice a day) to affected areas on left hip and cover with non-adherent pads for seven days every shift for blisters on skin. Start date 3/18/25 discontinue 3/23/25. R1's Treatment Administration Record dated 3/1/25 - 3/31/25 documents Apply Silvadene cream BID (twice a day) to affected areas on left hip and cover with non-adherent pads for seven days every shift for blisters on skin. Start date 3/24/25 discontinue 3/28/25. R1's Treatment Administration Record dated 3/1/25 - 3/31/25 documents Clean area to left hip with wound cleanser; apply Medi honey and cover with (dressing) and secure with tape daily until healed every day shift for wound healing. Start date 3/29/25. R1's Medication Administration Record dated 3/1/25 - 3/31/25 and 4/1/25 - 4/30/25 documents there is to be a pain assessment every shift on days and nights. Start date 12/8/24. (Pain is based on a 0 -10 scale) Pain was documented as follows; 3/17 both shifts 3 (three), 3/18 days 1 (one), nights 3, 3/22 days 7 (seven), 3/23 both shifts 5 (five), 3/24 both shifts 7, 3/26 both shifts 6 (six), 3/29 both shifts 6, 3/30 days 4 (four), 3/31 both shifts 5, 4/1 both shifts 4, 4/2 nights 3. (3/4/25 was the only time that pain was documented before the burn incident, and it was rated at a 3) The Food Temperature Chart for 3/16 to 3/22/25 does not document any temperatures for the Hot Coffee or Hot Tea. On 4/18/25 at 10:22 AM, V3/LPN stated I was not working the day of the accident, but I heard about it. (R1) was dependent on staff and should not have been handling a hot drink by herself. (R1) sits at the table where staff feed the residents. I was told that (R1) wanted hot [NAME]. The kitchen staff made it in the microwave. (V14/Cook) took it to the nurse's station to let it cool down and (V8/LPN) told (V14) to take it to (R1). (R1) was not able to hold her own cup or silverware. There were three burns, and they were large areas on (R1's) left hip in the front. They were nasty burns. They were painful for (R1). On 4/18/25 at 10:40 AM, V2/DON stated I was off and when I came in on Monday, I was told that (R1) spilled hot chocolate in her lap. There were four areas, three were pink and one had blisters. I did the assessment and called (V5/R1's Power of Attorney), the doctor, and talked to hospice. Staff had put the hot chocolate in a pitcher (large cup) that had a straw and a handle. (R1) could feed herself some but (R1) sits at a table to be assisted during meals. This was not at mealtime, and I don't know that anyone was there to help (R1) with the drink. I have no idea why it was so hot. They (kitchen staff) were not checking temperatures at that time. That process was not in place but evidently needed to be. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/18/25 at 10:50 AM, V4/Dietary Aide stated A CNA came to the kitchen and said that (R1) wanted some hot chocolate. We microwaved the water then added the ingredients. (V14/Cook) was who made the drink for (R1). (V14) took the drink to the nurse's station for it to cool down. (V14) was told to go ahead and take it to (R1). (V14) put the drink on the table in front of (R1). (R1) needed help with the drink because (R1) shakes. During meals (R1) sits at a table where staff can help (R1). Since this was not at mealtime, I don't think there were staff around to help (R1). On 4/18/25 at 11:23 AM, V5/R1's Power of Attorney stated (R1) was burned on 3/16/25 by spilling hot chocolate on herself. (R1) should have had someone help her with the drink. (R1) has Dementia, Bipolar, Schizophrenia, and physical limitations. (R1) is on hospice because of her declining health that required (R1) to have assistance or at least supervision. (V10/Hospice Nurse) told me the burns were not looking good with one of them being 19 cm by 9 cm in size and they were causing (R1) pain. I was upset because from what I was told by the facility the burns were minor, this does not seem minor to me. I know that accidents happen, but this is not acceptable. If there had been someone close by at least supervising (R1) they would have been able to quickly get the cup picked up so the burn area would not have been as large. I did not get good answers to how this accident happened and why there was no supervision. On 4/18/25 at 1:53 PM, V10/Hospice RN stated (R1) got a burn on her hip/thigh area from spilling hot chocolate on herself. When I saw the wound the areas had blistered then the blisters opened. There was slough in the wound bed. (R1) was started on a prophylactic antibiotic to prevent infection. The first treatment was Silvadene cream for seven days then it was changed to Medi honey. The burn was through the second layer of skin. (R1) was having pain due to the burn especially during dressing changes. Hydrocodone was ordered for pain relief and was to be given before dressing changes and as needed every 4 hours. V10 also stated (R1) needed supervision and help with all her activities of daily living including eating and drinking. On 4/18/25 at 2:04 PM, V11/R1's Primary Care Physician stated that R1's burn was a second degree burn and there is some degree of pain with any burn. The pain may range from moderate to severe. On 4/18/25 at 3:08 PM, V8/LPN stated I was at the nurse's desk when the kitchen brought out hot chocolate in a bedside cup for (R1). I told the kitchen staff to take the drink to (R1). Later I heard a commotion in the dining room. (R1) had spilled the hot chocolate on her leg. I took (R1) to her room and looked at her leg. It was just pink at the time. I called (V1/Administrator) and reported it. V8 also stated that at times R1 could eat and drink on her own. V8 was asked how it was determined if R1 was able to feed herself or needed assistance. V8 stated If there is a fork there and (R1) picks it up then she can feed herself. V8 also stated that she does not remember there being any staff in the dining room when R1 spilled the drink. On 4/18/25 at 3:19 PM V13/RN stated I was at the nurse's station when (R1) spilled the hot chocolate. It depends on the day if (R1) could feed herself. I don't remember there being any staff in the dining room with (R1). V13 also stated The wounds were not good; they were red then blistered and broke open. They were substantial. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/18/25 at 4:59 PM, V14/Cook stated I made the hot chocolate for (R1). I made it in the microwave. I don't know how hot it was. I did not take the temperature. That was not the protocol at the time. It was put in a blue cup with measurement lines on the side. The cup had a handle on it but no lid. I took the drink to the nurse's station and put it on the counter. The nurse said to give it to (R1). I did not know anything about how (R1) drinks, so I put it (hot chocolate) on the table instead of giving it to (R1). I don't remember there being any staff in the dining room. On 4/19/25 at 10:43 AM, V15/Previous Dietary Manager stated I was told that (R1) asked for hot chocolate. The kitchen staff asked the nurse if (R1) could have hot chocolate and the nurse said it was ok. The water for the drink was put in the microwave to get it hot. I don't know how hot it was. We were not temp testing the drinks or logging what the temp was. On 4/19/25 at 1:36 PM, V1/Administrator stated they did not have a hot liquid assessment for R1. On 4/19/25 at 1:42 PM, V17/CNA stated that she has worked at the facility for three years and was familiar with caring for R1. R1 ate at the assisted table and needed supervision when eating or drinking. Most days R1 was not with it enough to help herself and R1 was shaky.