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	09/03/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review the Facility failed to monitor and treat acute medical conditions for two of seven Residents (R4 and R9) reviewed for quality of care in a sample of nine. This failure resulted in R4 and R9 requiring hospitalization.Findings include:The Facility Physician Orders Policy, revised 2/14/23, documents: to provide guidance to ensure physician orders are transcribed and implemented in accordance with the professional standards.The Facility Acute Respiratory Illness Policy, initiated 1/31/25, documents: the Facility follows current guidelines and recommendations for managing acute respiratory illness; and is defined by two of the following signs and symptoms (shortness of breath/difficulty breathing, which may manifest as increased fatigue and low oxygen saturation in the blood (normal levels are between 95 percent and 100 percent, but may vary for people with certain medical conditions).The Facility Registered Nurse Job Description, undated, documents: ability to work independently or part of a group; direct day-to-day functions of the nursing assistants in accordance with current rules, regulations and guidelines that govern long-term care; ensure that all nursing personnel assigned to you comply with the written policies and procedures established by the Facility; responsible for complying with Facility policies and procedures; cooperate with other Resident services when coordinating nursing services to ensure that Resident's total regimen of care is maintained; participate in the development, maintenance and implementation of the Facility's Quality Assurance Program; perform all tasks in accordance with established policies and procedures and as instructed by supervisor; sign and date all entries made in the Resident medical record; charts nurses' notes in an informative, relevant, concise and descriptive manner that reflects the care provided to the Resident, as well as Resident's response to the care; provides direct Resident care; review the Resident chart for specific treatment and medication orders as necessary; implement and maintain established nursing objectives and standards; educates the Resident through use of nursing knowledge and skills according to their needs and promote their mental and physical well-being; responsible for interpretation and execution of Physician orders and calling Physician as indicated; make periodic rounds to observe and evaluate Resident's physical and emotional status and to ensure the continuing quality Resident care; assess the total needs of the Residents and adjust care plans as needed; reviews care plan daily to ensure that appropriate care is being rendered; responsible for accurate observation, evaluation and reporting of Residents symptoms and change of condition reactions and progress to the Physician and shift supervisor; assures Resident care delivery is in accordance with the Facility policies and procedures; notifies Resident's attending Physician and family when the Resident is involved in an occurrence or change in condition; responsible for administering and documenting medications according to the Physician order and plan of care; responsible for competent administration of care and treatments according to the Physician orders and Facility policy and procedure at a minimum; responsible for administration and control of narcotics and controlled drugs according to state and federal regulations, Facility policies and procedures; ensure that Residents who are unable to call for help are checked frequently; make periodic checks to ensure that prescribed treatments are being properly administered by nursing assistants; Resident Rights in regards to psychosocial needs and caring for aged, ill, disabled and cognitively impaired, Communication/Personal skills and Medication rights; ensure that all Residents are treated fairly and with kindness, dignity and respect; knowledgeable to all Residents' Rights according to Facility policy and Regulations; and ensure that call lights are answered by all employees of the Facility, regardless of the department.The Facility Resident Council Notes, dated 7/2023, document Nursing Department issues with Residents stating, a male nurse on night shift (V8/Agency Registered Nurse/RN) is still missing wound treatments and that V8 (RN) told the Resident Council member that it is the day nurse's job to do the wound treatment, not his. Residents also have concerns that V8 (RN) skips their medication pass (med pass) every time he works.The Facility Concern/Grievance Form, dated 7/2025, documents a concern with male nurse on night shift (V8/RN-Registered Nurse). The review and action taken documents that the Facility quit using (employing) V8 (Agency RN).1.R9's Physician Order Sheet/POS, dated 8/30/25, documents R9's diagnoses including Generalized Anxiety, Hypertension, Congestive Heart Failure, Obesity, Mitral Valve Stenosis, Repeated Falls, Cardiomyopathy, Recurrent Moderate Chronic Obstructive Pulmonary Disease/COPD, Emphysema, Anemia, Cerebral Infarction, Chronic Kidney Disease Stage Three and Chronic Respiratory Failure with Hypercapnia.R9's POS, dated 8/30/25, also documents Physician Orders for a breathing machine (Bi-pap), keep head of bed elevated at 30 degrees as needed for shortness of breath, Oxygen therapy at four liters per nasal cannula, Nebulizer treatment (Proventil, Ipratropium and

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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. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to prevent an injury for one of three residents (R1) reviewed for accidents in a sample of nine. This failure resulted in R1 receiving a large hematoma under both eyes and across the bridge of R1's nose causing R1 pain and requiring R1 be sent to the Emergency Room. Findings include:Resident Rights Handbook documents Your rights to safety 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.The Fall Reduction Policy dated 10/30/24, documents Purpose: to provide an environment that remains as free of accident hazards as possible. Definition of Fall: A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. A near fall is a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling. R1's computerized Medical Record documents that R1 is a [AGE] year-old female that admitted to the facility on [DATE] with diagnoses which included Systemic Lupus Erythematosus, Organ and System Involved Unspecified, Personal History of Transient Ischemic Attack, and Cerebral Infarction without Residual Deficits, Chronic Kidney Disease, Stage 3, Age-Related Osteoporosis without Current Pathological Fracture, Essential (Primary) Hypertension, and Generalized Anxiety Disorder.R1's MDS (Minimum Data Set) assessment dated [DATE] documents a BIMS (Brief Interview for Mental Status) of 15, indicating (cognition intact). R1 has no upper or lower extremity impairment, uses no devices for mobility, is independent for activities of daily living, bed mobility, and transfers. R1's Care Plan printed 8/30/25 documents (R1) currently has an alteration to her Integumentary System d/t (due to) Bruising. Date Initiated: 8/5/2025.On 8/28/25 at 11:20 AM, R1 was sitting in the dining room. R1 had a purplish/green bruising under both eyes and across the bridge of her nose. R1 stated several weeks ago R1 was going to her room on C Hall after supper and tripped over a rug. R1 did not fall to the floor but her head hit a door. R1 did not tell anyone although she did have pain. When R1 got up the next morning a nurse (V13/Registered Nurse/RN) noticed bruising on R1's face. R1 was sent to the hospital to be evaluated. R1 is currently getting Tylenol for pain. R1 also stated The rug was starting to come up on one end. There have been other people to trip over it (the mat). We (R2/Resident Council President and R1) complained that someone was going to get hurt. They (the facility) removed the rug after I got hurt.R1's Nursing Note dated 8/5/25 at 6:30 AM, documents (R1) was ambulating towards nurses' desk, as staff noticed (R1) to have her left eye swollen and black, and continued from her left eyebrow up to her hairline. When staff questioned (R1) as to what had happened, (R1) replied that she had tripped over the corner of the rug that is in front of the back door and the break room door. (R1) stated that (R1) didn't fall, (R1) had caught herself and apparently hit her head on the doorway. (R1) did not report to any staff as she stated she didn't think it was that bad. Neuro checks initiated. R1's Telehealth Note dated 8/5/25 at 7:00 AM, documents that a nurse reported that R1 experienced a fall last night after tripping over a rug and struck her head. Swelling and bruising were noted around the left eye, extending from the left eyebrow to the hairline. R1 was referred to the emergency room for further evaluation and treatment.R1's Incident Report dated 8/5/25 at 6:30 AM, documents (R1) was walking by nurses' station and nurses noted (R1) had a black, swollen eye and a bruised area to the top of her left side of head. (R1) stated after supper on 8/4/25 at around 7:30 PM (R1) walked out of the dining room and down the hall, when (R1) walked through the doorway (R1) hit the corner of the rug and tripped over it, (R1) states (R1) tried to catch herself and hit her eye and head on the break room doorway and door frame. Action Taken - R1 was assessed and sent to the Emergency Department for evaluation and treatment. Injury type - left eye. Predisposing Environmental Factors- Rugs/CarpetingR1's Emergency Department Notes dated 8/5/25 at 11:23 AM, document History of Present Illness - R1 presents following a fall at (the facility) 16 hours ago. The fall was described as tripped (over floor mat). Location: Left head (forehead eye (s). The character of symptoms is pain and swelling. The degree at present is 7/10 (Severe pain). A CT/Computed Tomography of R1's head, cervical spine, and facial bones were done. Findings A prominent left frontal scalp hematoma hyper attenuating therefore acute measuring about 4 (four) by 1 (one) cm (centimeters). Prominent Soft Tissue Hematoma in the left supraorbital and frontal scalp. Therapy today: over the counter medications including Tylenol and Naproxen. Associated symptoms: headache. Plan - Follow up with primary care physician and continue prescribed Tylenol and Naproxen for pain. R1's Nursing Note dated 8/8/25 at 8:27

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the Facility failed to identify, reconcile, document and investigate a missing controlled substance drug for one of seven Residents (R5) reviewed for controlled substances in a sample of nine.Findings include:The Facility Registered Nurse Job Description, undated, documents: ensure that all nursing personnel assigned to you comply with the written policies and procedures established by the Facility; responsible for complying with Facility policies and procedures; cooperate with other Resident services when coordinating nursing services to ensure that Resident's total regimen of care is maintained; dispose of drugs and narcotics as required, and in accordance with established procedures; perform all tasks in accordance with established policies and procedures and as instructed by supervisor; documents accurately in Resident chart any significant changes in care and services; sign and date all entries made in the Resident medical record; charts nurses' notes in an informative, relevant, concise and descriptive manner that reflects the care provided to the Resident; reports all discrepancies noted concerning physician orders or charting errors to the Director of Nursing; review the Resident chart for specific treatment and medication orders as necessary; implement and maintain established nursing objectives and standards; responsible for interpretation and execution of Physician orders and calling Physician as indicated; assures Resident care delivery is in accordance with the Facility policies and procedures; responsible for administering and documenting medications according to the Physician order and plan of care; responsible for competent administration of care and treatments according to the Physician orders and Facility policy and procedure at a minimum; responsible for administration and control of narcotics and controlled drugs according to state and federal regulations, Facility policies and procedures; and Resident Rights in regards Medication rights.The Facility Medication Error Management Policy and Procedure, revised 11/5/19, documents: to establish and follow a uniform process of medication error management; it is the responsibility of every employee to report any unknown, suspected or potential medication error and the responsibility of nursing administration to monitor these reports and initiate any appropriate action; each medication error or potential error identified will be investigated by nursing administration and be classified by their severity (Level Zero -non-medication error to Level Six -error occurred that resulted in death); accumulated medication error points in a rolling calendar year will be acted upon; and all actions will be accordance with the Facility's progressive disciplinary policy and may be modified according to the nature and effect of each error.The Facility Dispensing Controlled Substance Policy and Procedure, revised 8/23/22, documents: drugs listed as Schedule II, III, IV and V of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall not be accessible to any personnel other licensed nursing, pharmacy and medical personnel designated by the Facility; the Director of Nursing is designated by the Facility to be responsible for the control of such drugs; the Controlled Dangerous Substance Act of 1970 replaces existing laws regarding labeling, handling and accountability of narcotics, sedatives, stimulants and other drugs; Morphine is a Schedule II drug; a declining inventory sheet will be provided with each dispensed prescription for controlled dangerous substances and will contain the Resident name, medication (name, strength and dosage), name of prescriber, quality dispensed, prescription number and date dispensed; when the medication is administered, in addition to following proper procedure for the charting of medications, the nurse must document on the declining inventory sheet the date of administration, quantity administered, amount of medication remaining and his/her initials; an inventory count of the medications shall be performed at each change of shift by the outgoing and incoming nurse and will sign the inventory count; if a medication is lost or cannot be accounted for, the Director of Nursing must be notified immediately; the nurse/nurses discovering the loss must complete an incident Report indicating the circumstances surrounding the discovery and any steps taken to locate/verify the loss and will be forwarded to the Nursing Office; the Facility will complete a Report of Theft or Loss of Controlled Substance form and the form will be forwarded to the Pharmacy for reporting to appropriate agencies; and the Facility will investigate the loss if deemed necessary.R5's Physician Order Sheet, dated 8/29/25, documents: a Hospice Order (dated 4/25/25); Ativan 0.5 milligram/mg four times a day for restlessness; Fentanyl 12 microgram/mcg Transdermal 72 hour patch every three days for pain; Morphine Sulfate 0.25 milliliter/ml every two hours for mild pain (1-3/10), Morphine Sulfate 0.5 every two hours for moderate pain (4-6/10), Morphine Sulfate 1 .0 ml every two hours for severe pain (7-10/10); and Morphine Sulfate 0.5 ml by mouth four times a day for pain.R5's Nursing Progress Notes, dated 8/10/25 through 8/12/25, do not document V6's entries for the administration of Morphine Sulfate for