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No. 0938-0391

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	11/22/2024

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 33970 Based on observation, interview and record review the facility failed to ensure a resident ingested his medications for one resident (R2) of 24 residents reviewed during a routine medication pass observation. Findings Include: The Facility's Administering Medication policy dated 3/19/2020 documents the purpose of the policy and procedure is to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. The Facility's Administering Medication policy also documents Medications will remain secured in a locked cabinet/cart unless in direct view of the individual administering the medication. Self administration of drugs is permitted when approved by the attending physician and the interdisciplinary care planning team. R2's Medication Administration Record for November 2024 lists his medications scheduled at 7:00 AM as Famotidine 20 mg (milligrams), Lacosamide 50 mg, Pregabalin 100 mg, Levetiracetam 750 mg, Topiramate 100 mg, Oyster Shell Calcium 1500 mg, Potassium Chloride (Extended Release), Vitamin D3-50, and Acetaminophen 500 mg. On 11/20/24 at 8:15 AM R2 was in the main dining room eating his breakfast. On the table next to R2 was a clear medicine cup with 2 oblong white pills in it. R2 stated The nurse gave those to me earlier, I am working on them. On 11/20/24 at 8:20 AM V3 (Licensed Practical Nurse) confirmed that she had given R2 his medications a little bit ago and V3 stated that she should have stayed with R2 until he took all of his medications. He gets a lot of pills in the morning; I think those two pills are his (acetaminophen) or his calcium. On 11/21/24 at 1:00 PM V2 (Director of Nursing) stated that all residents should be observed taking all of their medications unless they have been assessed and care planned to self-administer their own medications. V2 confirmed that R2 had not been assessed or approved to self-administer medications.

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. 33970 Based on record review and interview the facility failed to have a completed discharge summary for one (R48) of one resident reviewed for discharge in a total sample of twenty four. Findings Include: The Facility's Transfer/Discharge policy dated 11/05/2023 documents The interdisciplinary team and or physician, in consult with the resident or his/her Power of Attorney for healthcare, may recommend transfers or discharges. Information vital for discharges to home include: a. Interdisciplinary discharge summary. R48's Interdisciplinary Discharge Summary for resident dated 10/16/2024 is filled out for Nursing Service Summary. The following areas on the Interdisciplinary Discharge Summary are blank : medications, social service summary, dietary service summary, activity service summary and rehab service summary. On 11/21/24 at 1:30 PM V2 (Director of Nursing) confirmed R48's discharge summary dated 10/16/24 was incomplete.

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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. 32189 Based on observation, interview and record review, the facility failed to ensure residents were transported to appointments as needed for one (R17) of three residents reviewed for transportation, failed to assess, document and provide appropriate treatment for a fungal infection for one (R8) of three residents reviewed for non-pressure skin impairments and failed to utilize a wheelchair positioning cushion for one (R8) of 14 residents reviewed for positioning in a total sample of twenty four. Findings Include: 1. The Transportation of Residents policy, dated 11/1/15, documented the facility will assist the resident in making transportation arrangements to and from the source of a service if the resident needs assistance. The Transportation calendar dated November 2024 documented R17 had a dental appointment on 11/19/24 at 11:15 AM. On 11/19/24 at 9:30 AM, R17 stated he was supposed to have a dentist appointment today at 11:15 AM, although, it was canceled due to the facility not having transportation staff available. On 11/20/24 at 11:32 AM, V5 (R17's family member) stated R17 had been waiting for this dental appointment for six months and was not aware the appointment was canceled due to transportation. V5 stated If I would have known, I would have taken him myself (to the appointment). On 11/20/24 at 12:15 PM, V2 (Director of Nursing/DON) stated the facility did not have transportation available to take R17 to his dentist appointment. V2 stated a calendar with the resident's appointments written on it was reviewed daily by the social worker or the Minimum Data Set (MDS) coordinator and they make transportation arrangements. On 11/21/24 at 9:34 AM, V17 (Ombudsman) stated she has been notified by residents during the last Resident Council Group (November 2024) that there have been ongoing transportation issues to medical appointments at the facility. 30899 2. Facility Policy/Medication and Treatment Orders dated 11/5/2019 documents: A current list of orders will be maintained in the clinical record of each resident. Treatment Orders: Orders should contain the required components of a complete order- Date and time of receipt of order; Name of practitioner providing the order; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Name and strength of product; Quantity or specific duration; Dosage and frequency of administration; Route of administration; Indication/diagnosis for which the product is given; Facility Policy/Skin Prevention, Assessment and Treatment dated 5/2/2022 documents: Treatment Guidelines: Any skin impairments, including pressure ulcers, non-pressure ulcers, surgical wounds, skin tears, abrasions, etc., should be assessed and documented weekly by the wound nurse, or designee, in the Medical Record. Documentation should cover all pertinent characteristics of existing ulcers, including location, size, depth, maceration, color of the ulcer and surrounding tissues, and a description of any drainage, eschar, necrosis, odor, tunneling, or undermining. Progress Note dated 10/30/24 at 4:25pm indicates CNA (Certifed Nurse Aid) reports that R8 has red, smelly groin. On assessment found (R8) has excoriated, angry red, slick, yeasty smelling pannus and redness goes down inside of both thighs. Physician notified with request for Fluconazole (oral antifungal). (V2, DON) suggests also using antifungal powder. Awaiting return call. Progress Note dated 10/31/24 at 2:50pm indicates Fluconazole ordered times three days for angry red, yeast smelling spots on groin area. Physician's Orders indicate R8 received Fluconazole(oral antifungal) 100mg (milligrams) daily for 3 days for Yeast Infection. Physician's Orders indicate R8 received Fluconazole (oral antifungal) 150mg (milligrams) daily for 5 days then one time per week for 6 weeks for Yeast Infection. On 11/19/24 at 1:40pm R8 was in bed and noted to have a bright, deep red skin excoriation between inner buttocks, up thru R8's perineum and into groin area and inner thighs which also had a musty fungal odor. R8's right leg was noted to rotate inward causing more friction and contact between R8's thighs. R8 stated the reddened area does hurt and itch. No residual topical cream or treatment was observed on the affected areas. At that time V15, CNA (Certified Nurse Assistant) stated that she had changed R8 earlier and doesn't know if any topical cream was applied by the nurse. V3, LPN (Licensed Practical Nurse) stated that she had seen R8's fungal skin area earlier in the morning and had applied cream to the area. V3 stated ointment is supposed to be put on the affected areas after each incontinent change. TAR (Treatment Administration Record) dated 11/1/24 - 11/30/24 indicates R8 receives Weekly skin checks and nurses are to document: C=Clear, R=Rash, O=Other, P=Pressure, S=Skin Tear. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	TAR dated 11/11/24 and 11/18/24 indicates R (Rash) on those dates. No corresponding documentation was found or presented that described R8's skin impairment characteristics. On 11/21/24 at 12:20pm V2, DON (Director of Nursing) stated staff were not documenting weekly skin assessments. V2 stated We hope to do better when we start electronic charting. TAR (Treatment Administration Record) indicates R8 receives Nystatin (antifungal) Cream to groin area at each incontinent change and as needed. Diagnosis: Yeast infection (groin area). dated 10/31/24. TAR indicates R8 received administration of treatment on all days of the month except 11/4, 11/5, 11/12 and 11/14. Physician's Orders dated 10/1/24 through 11/20/24 do not include orders for Nystatin Cream. On 11/20/24 at 10:10am V6, LPN looked through the treatment cart for R8's tube of Nystatin and couldn't find any treatment with R8's name. V6 stated Nystatin has to come from the pharmacy and there is no order. There hasn't been an order. I don't know who wrote that on the treatment sheet. It shouldn't have been written in there like that. I don't know what they've been using. I didn't put it on because there is no order. On 11/21/24 at 11:35am V14, Medical Doctor stated R8 also needs topical anti-fungal treatment and some type of barrier to prevent skin-to-skin contact. They should call me if the (affected areas) are not improving. It doesn't sound like the area has improved since starting the Diflucan. I'm going to order Nystatin to use in conjunction with the Diflucan. 3. Facility Policy/Turning and Positioning dated 11/5/2019 documents: To provide comfort to the resident, to prevent skin irritation and breakdown, and to promote good body alignment. Place pillows behind the resident's back to keep his/her body in proper alignment. Current Physician's Orders indicate R8 was admitted to the facility 8/9/24 and has diagnoses that include Cerebral Palsy, Osteoarthritis and Osteoporosis. Seating Mobility Evaluation (undated) indicates Limitations that may affect care: R8 leans to left side; upright sitting has decreased significantly. On 11/19/24 at 1:40pm R8 was sitting in her wheelchair in her room. R8 was leaning over the side arm of the wheelchair to her left side. The wheelchair arm was only minimally padded with a vinyl-like material on the top of the arm. The remainder of the arm was metal. No pillows or other type of padding or cushion was in R8's wheelchair to prevent R8 from leaning over the chair arm. R8 stated that she was waiting to be assisted into bed and that her left side gets sore when she is leaning into the side arm. R8 stated that she is waiting on a new, special wheelchair that will be better for her positioning but the chair she is in now does not accommodate her positioning needs. On 11/20/24 at 9:15am R8 was noted sitting in the dining room leaning to the left over the side arm of the wheelchair. No cushions, pillows or other positioning device was in place in R8's chair at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 9:30am V7, Director of Rehab stated R8 is supposed to have a cushion under her left hip when sitting in her wheelchair to keep her curved spine in a more upright position. On 11/21/24 at 10am V7 stated she found R8's cushion in another resident's room and placed it under R8's left hip in her wheelchair. At that time, R8 was noted to be sitting upright and not leaning to either side in her wheelchair. V7 stated that R8 had several room changes and R8's hip cushion was not moved with her into her current room. V7 stated either staff or R8 should tell V7 if the cushion is missing because R8 cannot sit upright without it. R8's current care plan does not include the hip/seat positioning cushion for R8's wheelchair. Care Plan does indicate to Maintain good body alignment to prevent contractures. Use braces and splints as ordered. Use assistive devices recommended by OT (Occupational Therapy.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 31285 Based on record review and interview the facility failed to identify triggers for PTSD (Post Traumatic Stress Disorder) and develop and care plan interventions related to PTSD for one (R31) of two residents reviewed for PTSD in a total sample of twenty four. Findings Include: R31's current medical record includes a Trauma Informed Care Screen, dated 2/26/24, documents R31 answered Yes when asked if he has experienced traumatic events. This trauma screen also documents R31 answered Yes when asked if has had nightmares about the event(s) and if (he) has tried hard not to think about the event(s), and if R31 went out of (his) way to avoid situations that reminded (him) of the event(s). The section of R31's Trauma Informed Screen, titled Potential Trigger(s) that May Cause a Reaction from Trauma Event is left blank, with no potential triggers documented nor interventions for the triggers. R31's current Careplan does not include PTSD triggers, nor interventions for R31's PTSD triggers. R31 declined to be interviewed. On 11/22/24 at 10:15am V19 and V21 RNs/Registered Nurses stated R31 has aggressive behaviors but they were not aware R31 has PTSD. On 11/21/24 at approximately 11:00am V2 DON/Director of Nurses stated that R31's medical record does not include PTSD triggers nor care planned interventions, but a PTSD Careplan should have been created when R31's PTSD was identified.

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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. 31285 Based on record review, observation and interview, the facility failed to employ a Dietary Manager with the appropriate competencies and skill to carry out the functions of Food Service Director. This failure has the potential to affect all 46 residents currently residing in the facility. Findings include: The facility's Resident Roster dated 11/19/24 documents 46 residents reside in the facility. The facility's job description for Food Service Director documents the following :Qualifications: 1. Bachelor of Science degree in Foods and Nutrition from an accredited college or university. 2. Graduation from a course in food service supervision which meets the established by the American Dietetic Association or graduate of another course in foods service supervision with ninety (90) or more hours in classroom instruction with on-the-job counseling by a dietician. On 11/19/24 at approximately 9:15am there was no Food Service Certification available or posted in the Dietary Manager's office. On 11/19/24 09:15am V9 (Dietary Manager) stated she did not have a Dietary Management Certificate and was not qualified to do the job of Dietary Manager. V9 stated, I do not have the certificate and I have told the Administrator. They are definitely aware of it. On 11/19/24 at 9:55am V9 stated she was not prepared to manage the kitchen or Dietary Department. V9 stated she was placed in this position approximately 1 month ago by the prior administration and has had no training for the Dietary Manager position. On 11/20/24 at approximately 10:30am V9 stated she has not taken any Food Service or Dietary Management classes. On 11/20/21 at approximately 10:45am V1 (Administrator) stated she was aware the facility's current Dietary Manager V9 did not meet the facility's qualifications for Food Service Director.

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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. 32189 Based on record review, observation and interview, the facility failed to ensure appropriate infection control practices were utilized in the Laundry Room, failed to ensure Legionella Risk Assessments were conducted annually and accurately with the designated team members, and failed to utilize Enhanced Barrier Precautions during a wound treatment for one (R1) of two residents reviewed for wound care in a sample of 24 residents. These failures have the potential to affect all residents who reside in the facility with a current census of 46 residents. Findings include: 1. The Handling Linens and Laundry policy, dated 11/1/15, documented to wash hands after handling soiled linen and before handling clean linen, consider all soiled linen to be potentially infectious and employees sorting or washing linens shall wear a gown/apron, gloves and if aerosolization occurs, a mask. The Hand Hygiene Policy, dated 11/1/15, documented Procedure and Implementation 1. Roll down paper towel. 7. Wipe hands dry with a clean single use paper towel. 8. Turn off the water with a paper towel and dispose of the towel. On 11/20/24 at 11:20 AM, the Laundry Room was observed to not have gowns or masks available for use and towels for hand hygiene (Personal Protective Equipment (PPE). On 11/20/24 at 11:25 AM, V4 (Housekeeping Supervisor) stated that resident's laundry who are on transmission-based precautions (TBP) is placed in a black bag and in a separate laundry bin. V4 stated V4 wears gloves when handling TBP laundry, although does not wear a gown. On 11/21/24 at 9:15 AM, V2 (Director of Nursing) stated laundry staff should be wearing gloves and gowns when handling all linen and paper towels should be available for hand washing. 2. The Infection Control Binder's section titled Legionella's policy documented the facility will perform an environmental assessment of the facility to identify where Legionella and other pathogens can grow and spread in the facility water system; the facility shall adopt a legionella prevention plan for their potable water system that identifies sites in the facility's water system that are susceptible and reviewed annually. The Legionella Policy and Procedure, no date, documented water temperatures and conditions are monitored to prevent the risk of Legionnaires Disease and to check hot and cold-water temperatures after water has been running for one minute weekly. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Legionella Management Procedure dated 8/10/18 documented the Legionella Management Team consisted of the Corporate Maintenance Director, Administrator and the Maintenance Personnel. The risk assessment shall be conducted on all storage tanks, calorifiers and associated pipework which are susceptible to colonization of Legionella. The risk assessment should take into account temperature of stored water, dimensions of water tanks, pipe distribution system, condition of showers and shower heads, water temperatures at hot and cold outlets after specified running times and susceptible residents. On completion of the risk assessment a monitoring regime will be formatted and inserted in the logbook, The facility shall have personnel who have been instructed, trained and who are competent to carry out weekly, monthly and quarterly monitoring. On 11/20/24 at 12:00 PM, V2 (Director of Nursing) provided a note that documented No Legionella testing because no standing water empty rooms per Admin (V1/Administrator) 11/20/24 11:41 PM (AM). Two facility Legionella Risk Assessments were reviewed, one dated 2016 and the other dated 11/5/24. The Legionella Environmental Assessment Form dated 11/5/24 completed by V1 (administrator) and V20 (Regional Maintenance Director) documented 10. Are there any cooling towers? No 23. Are cisterns and/or water storage holding tanks used to store potable water before it's heated? No 27. Are thermostatic mixing valves used? NO 28. How is the hot water system configured to deliver hot water to each building? Water heater with storage tank area served Laundry/Kitchen Appendix B. Cooling Tower ID (Identification) Chiller-by generator cools all except E and F hall and Appendix B pages three, four, five and six questions regarding General Cooling Tower Disinfection, Operation and Maintenance Characteristics were not completed. On 11/21/24 at 2:45 PM, V10 (Maintenance Director) stated that he did not know if there was a Water Management Plan and had not participated in a Legionella Risk Assessment. V10 reviewed the 11/5/24 Legionella Risk Assessment and stated three boilers were installed approximately two years ago to provide hot water to the A, B and C halls, the boilers stored water, the boilers have mixing valves and the facility did not have a chilling tower nor an E or F hall. V10 stated I think this (risk assessment) must have been from another facility. 33970 3. The Facility's Enhanced Barrier Precautions Policy dated 10/28/2024 documents It is this facility's policy that Enhanced Barrier Precautions (EBP) are used to prevent transmission of infectious organisms spread by direct or indirect contact with the patient or the patient's environment. They are a strategy in nursing homes to decrease transmission of CDC (Center for Disease Control) targeted and epidemiologically important MDROS (Multi Drug Resistant Organisms) when contact precautions do not apply EBP is used during high-contact activities for residents with chronic wounds or indwelling medical device, regardless of MDRO status. In addition to residents who have an infection or colonization with a CDC targeted or other epidemiologically important MDRO when contact precautions do not apply Facilities may have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents.' (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on record review and interview, the facility failed to ensure the antibiotic stewardship program accurately monitored infections and antibiotic use per policy for three of three residents (R7, R17, R25) reviewed in a sample of 46 residents. Findings include: The Infection Prevention and Control Program Standards policy dated 11/1/15 documented the Antibiotic Stewardship Committee will assess residents for infection using standardized tools and criteria, assess and reassess appropriateness and necessity, factoring in results of diagnostic tests, laboratory reports and/or changes in the clinical status of the resident, will develop and maintain a system to monitor antibiotic use which includes a review of antibiotics prescribed to residents upon admission or transfer to the facility or an antibiotic prescribed by a practitioner who is not part of the facility's staff. 1. The hospitalization record documented R7 was admitted to the hospital with a diagnosis of acute urinary tract infection (UTI) on 11/3/24. The record documented a past urine culture dated 10/24/24 that grew Escherichia coli and the sensitivity (test to determine appropriate antibiotic to treat infection) indicated Bactrim (antibiotic) should treat the infection. R7 was discharged back to the facility on [DATE] with a prescription and instructions to take Bactrim for seven days. The Hospital's Physician Progress Note dated 11/4/24 documented Evidenced on UA (urinalysis). Culture is positive for gram negative infection, but final ID (identification) and sensitivities are pending. The facility's medical record lacked documentation that on 10/24/24, R7 was sent to the hospital, the reason for the visit and/or the emergency department visit's findings. The Medication Record showed R7 was treated with Bactrim for 7 days. 2. The Emergency Department's urinalysis with urine culture report dated 9/6/24 documented R17 had a positive urine culture with greater than 100,000 Enterobacter cloacae complex (significant gram-negative, facultatively-anaerobic, rod-shaped bacterium associated with an increased mortality rate). 3. R25's Emergency Department Progress Note dated 10/14/24 documented R25 was transferred to the hospital for an evaluation after a fall at the facility. The Hospital's Discharge Summary dated 10/15/24 documented R25 had a urinalysis on 10/11/24 that showed an acute urinary tract infection and a positive culture for ESBL producing Klebsiella (extended-spectrum beta-lactamase which is an enzyme produced by some bacteria that makes them resistant to many antibiotics). A repeat urine culture was conducted in the Emergency Department on 10/14/24 and was growing gram negative rods and expected to grow Klebsiella Pneumonia. On 10/15/24, R25 was discharged back to the facility on Intravenous antibiotics for two weeks. The R25's facility's medical record lacked documentation that a urine for urinalysis and culture was obtained, the reason for the urinalysis, and any results from the test. The Medication Record showed R25 was treated with Meropenem (antibiotic) intravenously 10/15/24 through 10/25/24. (continued on next page)

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	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryview Care Center-Macomb	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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Monthly Infection and Antibiotic Tracking log available for review was dated 9/23/24 through 11/20/24. The following required information fields were blank: R7's 10/24/24 urinary tract infection; R7's 11/3/24 urinary tract infection's date of infection was incorrect, did not identify the source of culture or test, white blood cell count, colony count for urine, culture results and the prescribing physician's name; R17's 9/6/24 urinary tract infection; R25's 10/11/24 urinary tract infection; R25's 10/15/24 white blood cell count, colony count and culture results. On 11/20/24 at 11:00 AM, V2 (Director of Nursing) stated there was not a monthly infection and antibiotic tracking log prior to October 2024. V2 stated she was not aware of R7's 10/24/24 hospitalization and R7's 10/24/24, R17's 9/6/24 and R25's 10/11/24 urinary tract infection diagnosis. V2 stated hospitalization records and test results should have been obtained and documented on the Monthly Infection and Antibiotic tracking log. On 11/21/24 V2 provided R7's 10/24/24 urinalysis results and the hospital notes from the 10/24 hospital visit.