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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146080 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 01/14/2026 |
| NAME OF PROVIDER OR SUPPLIER Countryside Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 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.

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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on Observation, Interview and Record Review, the facility failed to ensure that direct resident care staffing was adequate to provide timely care and meet the needs of residents in the facility. This failure has the potential to affect all 44 residents residing in the facility. Findings include: The facility's Facility Assessment, dated 5/29/25, documents The facility must have sufficient staff with the appropriate competencies and skills sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. The facility's Resident Council minutes, dated 10/9/25, documents Residents want a night housekeeper. (Housekeeping addressed the staffing issue with residents. Telling them that they are short staffed and when they have enough people in the department (housekeeping) will training someone to go to nights.) Residents say that nurses and CNAs (Certified Nursing Assistants) are not responding to situations on time. Resident says she fell in the bathroom and yelled for help, but nobody came to help her. The facility's Resident Council minutes, dated 11/6/25, documents Multiple residents say that they're still not being assisted in the mornings. They are often left in bed past breakfast and the morning activity. Residents say they're still not being showered regularly. Some residents go a week without getting a bath or shower. Residents say the reason they aren't getting showered is due to lack of washcloths. The facility's Resident Council minutes, dated 12/11/25, documents Some residents go a week without getting a bath or shower, one resident stated they (staff) will put her down and forget about her. One resident stated she is not being showered properly during showers. Residents say it is still difficult to find a CNA willing to give them a shower. Some residents say the CNAs make them wait 20 minutes to get a response on their call lights. The facility's Resident Council minutes, dated 1/8/26, documents Residents say the kitchen isn't serving food on time and they are often waiting in the dining room for an hour before they are served. On 1/13/26 at 10:00 AM, a resident group meeting was held with R4, R6, R16, R19, R22, R26, R42, R46, and R47. During this meeting several residents stated it can take 45 minutes for call lights to be answered when the facility is short staffed. R22 stated Sometimes I wait 30 minutes to an hour for my call light to be answered. R16 stated Call lights take a long time. Sometimes 45 minutes and I have had incontinent accidents waiting to get help to the bathroom. I am incontinent some and wear a brief for it, but I still prefer to use the toilet. I can't hold it for that long. At this time, several residents stated that showers aren't being offered, and they believe it is usually due to the facility being short staffed. R6, R22 and R42 all stated they do not get a shower every week. R6 stated It's usually once every two weeks but I have gone three weeks without one. R22 stated I have to beg for a shower anymore. R6, R22 and R42 all stated that there is not laundry staff in the building at nights and on the weekends and sometimes the facility will run out of towels and washcloths. Several residents confirmed that CNAs will sometimes do laundry because if not then washcloths will run low and that takes the CNA's time away from being able to provide cares and answer call lights. During this same meeting, all residents in attendance confirmed that food in the dining room is often served cold because it will sit (continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>too long in the window waiting to be served and when delivered it is cold. On 1/13/26 at 9:30 AM, V9 (Certified Nursing Assistant/ CNA) stated that staff often do not give showers and if there is a shower aide, showers will only get done depending on staffing and call-ins. On 1/13/26 at 2:50 PM, V2 (Director of Nursing) confirmed that sometimes the facility has issues with adequate staffing. V2 stated When we are short staff it is typically because of CNA call offs. Retention is an issue and call offs are also an issue. On 1/14/26 at 3:00 PM, V1 (Administrator in Training) confirmed the facility does not have laundry services after 11:00 PM during the week and does not have laundry personnel in the facility at all on the weekends. V1 confirmed he has heard that CNAs will do laundry due to towels and washcloths running low and verified this could potentially affect their ability to provide required care to residents. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1 (Administrator in Training), documents 44 residents reside within the facility.</p> | | |

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| <p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Post nurse staffing information every day.</p> <p>Based on observation, interview, and record review the facility failed to post the Daily Staffing Report for 1/14/26 and failed to keep copies of the Daily Staffing Reports. This failure has the potential to affect all 44 residents residing within the facility. Findings include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1/Administrator documents 44 residents reside within the facility. On 1/14/26 at 9:10 AM, the Daily Staffing Report that was on the bulletin board was dated 1/13/26. As of 12:30 PM on 1/14/26 the Daily Staffing Report had not been updated. On 1/14/25 at 11:27 AM, V2/Director of Nursing/DON was asked for the last two weeks of the Daily Staffing Reports. V2 stated she does not have the Daily Staffing Reports and does not know what happens to the Daily Staffing Reports when they are taken down. V2 stated that the third shift nurse is supposed to fill out the Daily Staffing Report and post it on the bulletin board, but it doesn't always happen. V2 also stated if the nurse does not do the sheet V2 completes the posting at 8:00 AM when she arrives. On 1/14/26 at 1:01 PM, V1/Administrator in Training AIT stated that V2/DON is to be keep the Daily Staffing Reports for a couple of years. V1 also stated There is no reason (V2) doesn't have the previous days sheets immediately available. (V2) should not need to remake the sheets. V1 also stated that the Daily Staff Report should be posted in the morning by 6:00 AM. On 1/14/26 at 2:00 PM, V1/AIT stated that there is no policy about posting the Daily Staff Report.</p> | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and record review, the facility failed to maintain sanitary food storage and preparation, failed to label and date opened and prepared food items, failed to ensure food items were free from expiration, failed to wear gloves when checking food temperatures and handling resident meals, and failed to maintain safe holding temperatures for prepared foods on the steam table after reheating. These failures have the potential to affect all 44 residents residing in the facility. Findings Include: The facility's Refrigerators and Freezers policy dated 12/30/2024 documents, Policy Statement, the facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Policy interpretation and implementation, 6. All food shall be appropriately dated to ensure proper rotation. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Expiration dates on unopened food will be observed and a three-day expiration once food is opened. The facility's Food Storage Areas policy dated 12/30/2024 documents, Policy Statement, food storage areas shall be maintained in a clean, safe, and sanitary manner. Policy interpretation and implementation, 5. Prepared food stored in the refrigerator until service shall be dated. The facility's Food Temperatures policy dated 12/30/2024 documents, Policy Statement, food shall be stored in accordance with local, state, and federal guidelines. Policy interpretation and implementation, 1. Food will be stored in accordance with local, state, and federal guidelines. 5. Food will be cooked to the appropriate internal temperature per regulation. 9. Hot foods being reheated will be reheated to 165°F (Fahrenheit) or above for 15 seconds. On 1/12/2026 at 10:00 AM, during an initial kitchen visit with V16 (Dietary Manager), the following was observed in the freezer: 1/4 bag of frozen sugar cookies not labeled or dated. 1/2 bag of frozen fish patties not labeled or dated. 1/2 bag of frozen garlic bread slices not labeled or dated. 1/4 bag of hamburger patties not labeled or dated. In the refrigerator, the following was observed: One 10-ounce bar of opened margarine with no date, three ham and cheese sandwiches on a plate with saran wrap, no label, and no date, one diced pears tub, 1/2 full, made on 01/05/2026 with an expiration date of 01/09/2026, one medium-sized container with a brown substance covered with saran wrap, no label, and no date, one container with four cooked chicken breasts made on 12/29/2025 with an expiration date of 01/04/2026, one tub of mayonnaise, 3/4 full, not dated, 1/4 container of soy sauce not dated, Italian dressing tub, 1/4 full, not dated, a container with 15-20 slices of yellow square cheese, no label, and no date, a two-quart container full of pineapple chunks, not labeled or dated. In the dry storage room at 10:20 AM, the following was observed: A basket with five snack-size plastic bags of cereal and chocolate chips, not labeled or dated, a container of rolled oats, not dated, 1/2 bag of elbow macaroni, not dated, 1/2 loaf of raisin bread, not dated. On 1/12/2026 at 11:20 AM, during steam table temperature checks with V17 (Cook) V17 did not wear gloves and used the facility food thermometer to check the chicken tenders' temperature on the steam table, touching the chicken tender directly. V17 then picked up a roll with her bare hand and stated she could not take the temperature of the roll. V17 stated, I should be wearing gloves. V17 continued taking temperatures. When checking the mechanical chicken tenders, the thermometer read 112 F (Fahrenheit). V17 reheated the mechanical chicken, and the thermometer then read 140 F. V17 stated, It is supposed to be at 140 degrees Fahrenheit. V17 was going to serve the chicken tenders to residents until V16 (Dietary Manager) instructed V17 to discard the mechanical chicken. The chicken was not served to residents. On 1/12/2026 at 11:30 AM, V16 (Dietary Manager) stated all foods should be labeled and dated, all expired foods should be discarded, staff should always wear gloves when handling food, and when reheating food on the steam table, the temperature should be at least 165 degrees Fahrenheit. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1/Administrator documents 44 residents reside within the facility.</p> | | |

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| <p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview and record review the facility failed to document the number of Registered Nurses/RNs, Licensed Practical Nurses/LPNs, and Certified Nursing Assistants/CNAs in the Facility Assessment needed to meet the needs of the residents. This failure has the potential to affect all 44 residents residing in the facility. Findings include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1/Administrator documents 44 residents reside within the facility. The facility's Facility Assessment revised 5/29/25 by V1/Administrator in Training/AIT documents The Facility Assessment is a complete review of internal human and physical resources required by the facility to care for residents competently during day to day and emergency operations. The facility assessment identifies your capabilities as a skilled nursing service provider. The Facility Assessment will be the basis for surveyors to ascertain whether you are prepared to competently take care of the population you have identified that you serve. There are three components to the review: 3. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community based risk assessment, and other information that you may choose. This same assessment lists the daily average census as 49. On page 21 of 32 it does not list the number of RNs or LPNs required to meet the needs of the residents and lists 0 (zero) CNAs needed. On 1/14/26 at 2:55 PM, V1/AIT verified that the staffing numbers needed for RNs, LPNs, and CNAs was not documented in the Facility Assessment but should have been.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Provide and implement an infection prevention and control program.</p> <p>Based on Interview and Record Review, the facility failed to record and track employee reported illnesses. This failure has the potential to affect all 44 residents residing in the facility. Findings include: The facility's Infection Prevention and Control Program policy, dated 10/28/24, documents An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections. This same policy documents Monitoring Employee Health and Safety. The facility has established policies and procedures regarding infection control among employees, contractors, vendors, visitors, and volunteers, including: situations when these individuals should report their infections or avoid the facility (for example, draining skin wounds, active respiratory infections with considerable coughing and sneezing, or frequent diarrheal stools). On 1/14/26 at 11:00 AM, V3 (Licensed Practical Nurse/ Infection Preventionist/ Assistant Director of Nursing) confirmed the facility does not have any tracking or logs to monitor when an employee calls in sick. V3 stated I do not have any tracking of employee illness for call offs from infection or illness prior to January 2026. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1 (Administrator in Training), documents 44 residents reside within the facility.</p> | | |

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| <p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>Based on Interview and Record Review, the facility failed to offer COVID-19 immunizations to its employees. This failure has the potential to affect all 44 residents residing in the facility. Findings include: The facility's COVID-19 Vaccination policy, dated 7/15/21, documents it is the policy of this facility to have an infection control program that addresses a need to reduce the overall incidence of COVID-19 by offering to immunize all employees and residents. All residents and staff members are to be offered the COVID-19 vaccine unless the immunization is medically contraindicated, or the resident or staff member has already been immunized. The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine. On 1/14/26 at 11:00 AM, V3 (Licensed Practical Nurse/ Infection Preventionist/ Assistant Director of Nursing) verified the facility does not have documentation to show that employees are offered the COVID-19 vaccine. V3 stated Employees are not being offered to the COVID-19 vaccine from the facility. I was not aware that it is a requirement. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1 (Administrator in Training), documents 44 residents reside within the facility.</p> | | |

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| <p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>Based on interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) were provided and completed Dementia and Abuse training in a 12-month period. This failure has the potential to affect all 44 residents residing in the facility. Findings include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 1/12/26 and signed by V1/Administrator documents 44 residents reside within the facility. The facility's Facility Assessment revised 5/29/25 by V1/Administrator in Training/AIT documents that Certified Nursing Assistants should receive training for Abuse and Dementia upon hire and annually. On 1/14/26 at 1:10 PM, V11/Human Resources/Business Office Manager stated that she could not provide the required training that the Certified Nursing Assistants received. V11 also stated she did not know what V15/Prior Director of Nursing did with the training information. V11 stated I can't say they (CNAs) have received training, but they should have. I have some in-services but not the required training. On 1/14/26 at 2:55 PM, V1/Administrator in Training verified that he could not provide the training records for the CNAs.</p> | | |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide showers as scheduled for six (R4, R6, R7, R22, R23, and R42) of six residents reviewed for Activities of Daily Living (ADL) care in the sample list of 28. Findings include: The facility's Shower Care policy revised 12/24/2020 documents it is the practice of this facility to assist residents with bathing to maintain proper hygiene and help prevent skin issues. Showers/Baths/ Bed Baths are offered per regulation and taking into account personal preferences. The facility's Resident Council minutes, dated 11/6/25, documents Residents say they're still not being showered regularly. Some residents go a week without getting a bath or shower. The facility's Resident Council minutes, dated 12/11/25, documents Resident's say they're still not being showered regularly. Some residents go a week without getting a bath or shower, one resident stated they (staff) will put her down and forget about her. One resident stated she is not being showered properly during showers. 1. On 1/13/26 at 10:15 AM, during a resident group meeting, R6, R22 and R42 all stated they do not get a shower every week. R6 stated It's usually once every two weeks but I have gone three weeks without one. R22 stated I have to beg for a shower anymore. 2. On 1/13/2026 at 9:15 AM, R23 stated, I do not get showers every week. Sometimes I get a shower every two weeks and sometimes it's longer. I will ask staff to shower me, and they say they will get to it, but they never come back. On 1/13/25 at 9:10 AM, R23 was lying in bed with his eyes open, R23 had a strong urine odor upon entering R23's room. R23's current care plan documents that R23 will receive a shower twice a week. R23's shower task dated 12/31/2025 through 1/13/2026 documents that R23 did not receive a shower during this period. R23's electronic medical record does not contain documentation as to why R23 did not receive a shower from 12/31/25-1/13/25. 3. On 1/13/2026 at 9:18 AM, R4 stated she does not receive showers because she has an open area on her chest so staff say they cannot shower her. R4's shower task dated 12/17/2025 through 1/13/2026 documents that R4 did not receive a shower during this period. R4's electronic medical record does not contain documentation as to why R4 did not receive a shower from 12/17/25-1/13/25. On 1/13/2026 at 9:30 AM, V9 (Certified Nursing Assistant/ CNA) stated that staff often do not give showers and if there is a shower aide, showers will get done depending on staffing and call-ins. V7 stated that R4 had an offensive odor during morning cares on 1/13/25 and does not believe R4 has had a shower recently. 4. R7's shower task dated 12/16/2025 through 01/13/2026 documents that R7 did not receive a shower during this period. R7's electronic medical record does not contain documentation as to why R7 did not receive a shower from 12/16/25-1/13/25. R7's Minimum Data Set, dated [DATE] documents that R7 is dependent on staff for showers and bathing. This same MDS documents R7 is cognitively impaired. On 1/13/25 at 1:30 PM, V2 (Director of Nursing) stated she was not aware residents were not receiving showers.</p> | | |

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| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen therapy equipment was maintained and labeled according to facility policy, and failed to ensure oxygen safety signage was posted for residents receiving oxygen therapy for five (R1, R6, R12, R17, and R34) of five residents reviewed for oxygen therapy in the sample list of 28. Findings include: The facility's Oxygen Administration and Storage Policy revised 3/8/2022 documents to ensure staff follow guidelines for storage and use of oxygen. Staff are to label the tubing connected to the oxygen concentrator with time and date and to place an Oxygen in Use sign on the resident's door/door frame. 1. On 1/12/26 at 10:40 AM, R1 was sitting in her room wearing oxygen. There was no oxygen sign on R1's door. R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses which included Chronic Respiratory Failure with Hypercapnia, Depression, Atrial Fibrillation, Panlobular Emphysema, Chronic Obstructive Pulmonary Disease, Anxiety, Chronic Kidney Disease (stage 3), and Essential (Primary) Hypertension. R1's Physician Orders printed 1/14/26 at 12:50 PM, document that R1 is to have oxygen at two to four liters per minute by nasal cannula every shift. Order date 9/26/25. R1's current Care Plan documents that R1 has an alteration to her respiratory system and requires oxygen at four liters. 2. On 1/12/26 at 10:30 AM, R6 was lying in bed wearing oxygen. There was no oxygen sign on R6's door. R6's admission Record documents that R6 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Bipolar Disorder and Obsessive- Compulsive Personality Disorder. On 1/21/25 R6 was diagnosed with Asthma. R6's Physician Orders printed 1/14/26 at 12:48 PM, document that R6 is to have oxygen at two liters per minute by nasal cannula as needed. Order date 12/30/25. R6's current Care Plan documents that R6 has an alteration to her Respiratory System and requires oxygen therapy. 3. On 1/12/26 at 10:47 AM, R7 was lying in bed wearing oxygen. There was no oxygen sign on R17's door. R17's admission Record documents that R17 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Chronic Obstructive Pulmonary Disease, Asthma, Shortness of Breath. R6's Physician Orders printed 1/14/26 at 13:11 PM, document that R17 is to have oxygen at two to four liters per minute by nasal cannula every shift. Order date 9/26/25. R17's current Care Plan documents that R17 is currently on oxygen related to Chronic Obstructive Pulmonary Disease and Asthma. 4. On 1/12/26 at 10:30 AM, R12 was sitting on the edge of her bed with Oxygen on her face via nasal cannula. R12's Oxygen tubing and humidity bottle was not dated. R12 stated she does not think anyone checks the Oxygen and she does not know how they would be alerted if the tank ran out. On 1/13/26 at 2:50 PM, V2 (Director of Nursing) confirmed that Oxygen tubing and humidity bottles should have dates on them when they are changed. V2 stated They are supposed to be changed every Sunday night, and the staff should place a label with the date of change. 5. R34's admission Record dated 1/14/2026 documents, R34 has a medical diagnosis of Obstructive Sleep Apnea, Chronic Obstructive Pulmonary Disease, and Shortness of Breath. R34's Current Physicians Orders dated 1/14/2026 documents, R34 has an order for oxygen at 2L (liters) per nasal cannula as needed. On 1/12/2026 at 9:30 AM, R34 had an oxygen machine in her room next to her bed. Oxygen tubing was not labeled; R34's humidification bottle was labeled 1/2/2026. On 1/13/2026 at 10:30 AM, R34 had an oxygen machine in her room next to her bed. Oxygen tubing was not labeled; R3's humidification bottle was labeled 1/2/2026. On 1/13/2026 at 10:40 AM, V7 (Certified Nurse Assistant) confirmed that there was no label on R34's oxygen tubing, and R34's humidification was bottle was dated 1/2/2026. On 1/14/2026 at 10:45 AM, V3 (Assistant Director of Nursing) confirmed all oxygen tubing should be dated, and humidification bottles and tubing should be changed weekly. On 1/14/25 at 11:33 AM, V2 (Director of Nursing) stated that if a resident uses oxygen a sign should be posted on the door outside of the room. V2 confirmed that (R1, R6, and R17) did not have an oxygen sign outside of their door and should have one.</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Countryside Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 400 West Grant Street Macomb, IL 61455 | |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, and record review the facility failed to clean and disinfect a resident's wheelchair that had brown fecal matter smeared on the seat daily for one of four residents (R34) reviewed for dignity in a sample of 28. Findings Include: The facility's Resident Rights policy dated 11/5/2019 documents, It is the policy of this facility to respect the rights of the resident by providing comprehensive care with an approach aimed at maintaining dignity while respecting the core rights of patients and residents as outlined by the State Department of Public Health, Centers for Medicare and Medicaid (CMS) and Joint Commission of Healthcare Organization (JCAHO). Recognizing that society is dynamic, and the rights of residents are continually evolving; we will strive to improve the quality of our care through a multi-disciplinary approach recognizing that each resident is an individual with unique needs. The facility's Cleaning and Disinfection of Resident Care Equipment dated 3/24/2023 documents, Purpose: to provide guidelines for disinfection in accordance with manufacturer recommendations for reusable equipment used in resident care. Reusable resident care equipment includes wheelchairs. Procedure: 1. Reusable equipment will be cleaned and disinfected after use of one resident and before the use of another resident. R34's MDS (Minimum Data Set) section C dated 12/16/2025 documents R34 has BIMS (Brief Interview for Mental Status) score of 15, meaning cognitively intact. R34's MDS section C dated 12/16/2025 documents R34 uses a wheelchair. On 1/12/2026 at 9:30 AM, R34's wheelchair had a cotton pad cloth resting in her wheelchair with brown fecal matter smeared on the cotton pad cloth. On 1/13/2026 at 10:30 AM, R34's wheelchair had a cotton pad cloth resting in her wheelchair with brown fecal matter smeared on the cotton pad cloth. On 1/13/2026 at 10:40 AM, V7 (Certified Nurse Assistant) confirmed the brown fecal matter on R34's wheelchair. On 1/14/2026 at 10:20 AM, R34 was in her wheelchair, R34 got up and underneath her was a cotton pad cloth resting in her wheelchair with brown fecal matter smeared on the cotton pad cloth. R34 stated she always has brown fecal matter in her wheelchair and when she asks facility staff if they could change it they often tell me they ran out of pads cloths. On 1/14/2026 at 10:45 AM, V3 (Assistant Director of Nursing) stated staff should always change R34's cotton pad cloth, and that R34 should not have to sit in a dirty wheelchair with fecal matter in it.</p> | | |

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| <p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on Interview and Record Review, the facility failed to ensure resident mail was delivered unopened for two of nine residents (R42, R47) reviewed for resident rights in the sample of 28. Finding include: The facility's Ombudsman Program Resident's Rights for People in Long Term Care pamphlet (undated), documents Your rights to privacy and confidentiality. Your facility must deliver and send your mail promptly. Your facility may not open your mail without your permission. On 1/13/26 at 10:20 AM, R42 and R47 both stated that sometimes mail is opened when delivered to them. R47 stated My mail was opened one time, and I went to (V1, Administrator in Training) about it. R42 stated They (staff) open my packages and envelopes all the time. They are not opened in front of me. R42 confirmed that she frequently gets packages that have been opened without her permission and that V8 (Social Service Director) is usually the one opening them. On 1/14/25 at 11:45 AM, V8 stated that she has opened mail with scissors prior to delivering the packages to resident rooms. V8 stated I do that, so I don't have to take scissors to resident rooms. V8 confirmed that when this has happened the resident(s) was not aware and was not with her to watch the package be opened.</p> | | |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on Interview and Record Review, the facility failed to implement their abuse policy when an allegation of staff to resident physical/sexual abuse was received for one of two residents (R12) reviewed for abuse in the sample of 28. Findings include: The facility's Resident Right to Freedom from Abuse, Neglect and Exploitation policy, dated 10/16/23, documents The facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the facility (Associates). This same policy documents Associates must not use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion against any resident. When the facility has identified abuse, the facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The facility will increase enforcement action, including, but not limited to: Taking steps to prevent further potential abuse. Reporting the alleged violation and investigation within required timeframes. Conducting a thorough investigation of the alleged violation. The facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility shall: ensure all alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to this policy. Have evidence that all alleged violations are thoroughly investigated. On 1/12/26 at 10:30 AM, R12 stated she recently had an incident with a male CNA (Certified Nursing Assistant, V12). R12 stated when V12 was assisting her with toileting he smacked her behind and she was very angry about it. R12 stated she did inform the facility staff about it, and she was very bothered by the incident. On 1/13/26 at 8:30 AM, V1 (Administrator in Training) stated he does not have any abuse investigations for the past six months. V1 stated I just started in May 2025, and I have none. If there have been any allegations or investigations prior to me starting, I am not sure where they are kept. I am not aware of any though prior to me working here. On 1/13/26 at 3:05 PM, V1 confirmed he is the facility's abuse coordinator and in December 2025, there was an incident between R12 and V12. V1 stated I don't have any interviews related to the allegation of (V12) hitting (R12) on the behind. I interviewed (V12) but it was related to the other staff issues, not the allegation from (R12). I did not record any interviews related to this allegation. I did not interview other residents about this employee. I do not have an investigation to provide or documentation to related to any investigation into the incident between (R12) and (V12).</p> | | |

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| <p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Respond appropriately to all alleged violations.</p> <p>Based on Observation, Interview and Record Review, the facility failed to investigate and document an allegation of staff to resident physical/sexual abuse for one of two residents (R12) reviewed for abuse in the sample of 28. Findings include: The facility's Resident Right to Freedom from Abuse, Neglect and Exploitation policy, dated 10/16/23, documents The facility's residents have the right to be free from abuse, neglect, misappropriation of their property, and exploitation as defined in this policy. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This policy applies to any and all owners, directors, officers, clinical staff, employees, independent contractors, consultants, and others currently or potentially working for the facility (Associates). This same policy documents The facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property. In response to allegations of abuse, neglect, exploitation or mistreatment, the facility shall: ensure all alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported in the proper timeframe pursuant to this policy. Have evidence that all alleged violations are thoroughly investigated. On 1/12/26 at 10:30 AM, R12 was in her room sitting on the edge of the bed. R12 stated she recently had an incident with a male CNA (Certified Nursing Assistant, V12) while toileting. R12 stated after toileting she was trying to get her underwear pulled up and V12 was assisting but struggling to help her. R12 stated I kept telling him to lift them up higher in the front, but he kept pulling on them in the back and finally I got him to understand, and we got them pulled up in the front. After we did this, I bent forward to position myself and get ready to walk back to bed with my walker and at that time (V12) took his hand and smacked me on the butt! I was so mad and immediately by instinct, balled my hand into a fist because I wanted to hit him. When I got back to bed, he asked me if I was ok and I said, leave my room, now! Then (V12) said fine and left my room. It made me angry that (V12) did that. It was not ok, and I didn't appreciate it. R12's current medical record does not document any investigations, incidents or interventions related to abuse or allegations of abuse from staff towards R12. On 1/13/26 at 8:30 AM, V1 (Administrator in Training) stated he does not have any abuse investigations for the past six months. V1 stated I just started in May 2025, and I have none. If there have been any allegations or investigations prior to me starting, I am not sure where they are kept. I am not aware of any though prior to me working here. On 1/13/26 at 2:50 PM, V2 (Director of Nursing) stated on 12/16/25 when she got to work (unknown) staff came to her and reported that R12 needed to speak to her. V2 stated I went down and talked to her after a CNA (unknown) told me what (R12) was saying. I think the Administrator (V1, Administrator in Training) found out at the same time as me and (V3, Assistant Director of Nursing). I don't have documentation of an investigation. (V1) is the abuse coordinator, I am not sure if he reported the allegation or kept records of an investigation. On 1/13/26 at 3:05 PM, V1 confirmed he is the facility's abuse coordinator and in December 2025, there was an incident between R12 and V12. V1 stated we were already looking at this CNA's file due to an issue with staff and unrelated to residents. V1 verified that he was notified by nursing staff on the morning of 12/16/25 of an allegation between R12 and V12. V1 stated My regional (unknown corporate consultant) told me not to report it because it didn't qualify as abuse. I don't have any interviews related to the incident. I interviewed (V12) but it was related to the other stuff. I did not record any interviews related to this allegation. I did not interview other residents about this employee. I do not have an investigation to provide or documentation to related to any investigation into the incident between (R12) and (V12).</p> | | |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide the ombudsman an accurate notification of admission/discharges for one of two residents (R1) reviewed for discharge process in the sample of 28. Findings include: The Discharge/Transfer policy not dated documents Purpose To ensure that (the facility): I. Permits each resident to remain in the Facility unless the conditions that allow for transfer or discharge are met; II. Properly document resident transfers and discharges; III. Has a standardized discharge planning process that addresses residents' discharge goals and needs and involves residents and their interdisciplinary team; and IV. Transfers or discharges residents in a safe manner. Policy: Once admitted, residents have a right to remain in the Facility. Discharging a resident is a violation of the right unless the Facility can demonstrate that the conditions that allow for a transfer or discharge are met. To that end, it is the Facility's policy to permit each resident to remain in the Facility unless it can demonstrate that the conditions that allow for a transfer or discharge are met. If the Facility can demonstrate that those conditions are met, the Facility present according to consumer procedures set forth below. Notice before transfer: A. Before the Facility transfers or discharges a resident, the Facility shall: a. Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in language and manner they understand. Send a copy of the notice to a representative of the office of the State Farm care on. A. The facility shall maintain that the notice was sent to the ombudsman. a. Record the reasons for the transfer or discharge in residence in accordance with policy and procedure. b. The items described in paragraph B below. B. Contents of the notice. a. The written notice shall include the following: i. The reason for transfer or discharge; ii. The effective date of transfer or discharge; iii. The specific location to which the resident is transferred or discharged (such as the name of the new provider or description and/or address if the location is a residence) R1's Face Sheet documents R1 was admitted to the facility on [DATE] with diagnoses which included Chronic Respiratory Failure with Hypercapnia, Depression, Atrial Fibrillation, Panlobular Emphysema, Chronic Obstructive Pulmonary Disease, Anxiety, Chronic Kidney Disease (stage 3), and Essential (Primary) Hypertension. R1's Census List printed 1/14/26 documents that R1 transferred out to the hospital on 8/26/25 to 9/1/25 and 9/17/25 to 9/26/25. R1's Nursing Note dated 8/25/25 at 11:51 PM, documents Transfer to Hospital. for Shortness of Breath. R1's Nursing Note dated 9/1/25 at 6:22 PM, documents that R1 returned from the hospital with diagnosis of Acute Respiratory Failure. R1's Nursing Note dated 9/17/25 at 4:20 PM, documents that Emergency Medical Services were called to the facility to take R1 to the hospital due to R1 struggling to breath and oxygen level at 39 percent. R1's Nursing Note dated 9/26/25 at 2:38 PM, documents that R1 returned from the hospital. The Admission/Discharge Report dated 8/1/25 to 8/31/25 does not include R1's transfer to the hospital on 8/26/25. The Admission/Discharge Report dated 9/1/25 to 9/30/25 does not include R1's readmission to the facility on 9/1/25. It also does not include R1 going to the hospital on 9/17/25 or readmitting to the facility on 9/26/25. On 1/13/26 at 1:44 PM, V14/Ombudsman stated that she gets a list sent to her at the end of the month for resident admissions and discharges. V14 also stated I don't believe the list that is provided is complete and accurate. On 1/13/26 at 2:29 PM, V1/Administrator in Training stated that the list of admission/discharges is sent to V14/Ombudsman at the end of the month. V1 also stated that he was told that if the resident is on Medicaid they need to be gone for ten days, a Medicare resident for three days, and Private pay resident for one day before they need to be included on the discharge sheet.</p> | | |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure a residents Minimum Data Set assessment (MDS) was completed accurately to reflect medications for one of three residents (R2) reviewed for Resident Assessment in the sample of 28. Findings include: The facility's Minimum Data Set (MDS) policy, dated 11/05/2019, documents its purpose is To provide guidance to conduct initially and periodically a comprehensive, accurate and standardized reproducible assessment of each resident's functional capacity through utilization of the MDS 3.0 Patient Driven Payment Model (PDPM) User's Manual. R2's MDS, dated [DATE], documents R2 is receiving an anticoagulant medication. R2's Medication Administration Record, dated 10/1/25-10/31/25, does not document an anticoagulant medication was administered. On 1/14/2026 at 1:00pm, V2 (Director of Nursing) confirmed that R2's medical record does not document R2 was taking an anticoagulant medication at the time of his assessment. V2 stated she does not recall R2 ever being on an anticoagulant medication and stated R2's MDS assessment must have been coded incorrectly.</p> | | |

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| <p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to refer a resident to the PASRR (Preadmission Screening and Resident Review) State Agency to obtain a Level II PASRR after being diagnosed with Schizophrenia for one of five residents (R6) reviewed for Mental Illness in the sample of 28. Findings Include: The Pre-admission Screening and Resident review (PASRR) policy dated 2/2/24 documents This facility coordinates with the preadmission screening and resident review (PASRR) program to ensure that residents are appropriately placed in nursing homes for Long-Term Care. 4. Any level II resident who experiences a significant change in status will be referred promptly to the State mental health or intellectual disability authority for additional resident review. 5. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability or a related condition will be referred promptly to the State mental health or intellectual authority for a level II resident review. R6's admission Record documents that R6 was admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Bipolar Disorder and Obsessive- Compulsive Personality Disorder. R6 was readmitted to the facility on [DATE] with Schizoaffective Disorder and Post-Traumatic Stress Disorder. On 1/21/25 R6 was diagnosed with Schizophrenia. R6's PASRR Level I dated 10/16/24 documents Mental Health Diagnoses as Major Depression and Bipolar Disorder. Medical Conditions are listed as Post-Traumatic Stress Disorder, Severe Major Depression with Psychotic features. The PASRR Outcome Explanation documents The nursing facility must do a RR (Resident Review) when: A resident's condition changes. Important Information After you admit to the nursing facility, your PASRR Level II evaluation remains good during your stay. Your evaluation should go with you if you move to a different nursing facility. If you experience a significant change in your physical or mental health, you may need a new Level II evaluation. The nursing facility must submit an updated Level I screening to Maximus to see if further PASRR evaluation is needed. R6's PASRR Level II dated 10/19/24 documents You have a Level II PASRR condition of Depression, Bipolar Disorder, Major Depressive Disorder Severe with Psychotic Features, Anxiety Disorder, and Post Traumatic Stress Disorder, which needs routine follow up with a mental health professional, and a medication regimen including Latuda and Fluvoxamine. R6's current Care Plan documents that R6 uses psychotropic medication related to Major Depressive Disorder, Anxiety, Schizophrenia, Obsessive-Compulsive Disorder, and Post-Traumatic Stress Disorder. R6's Medical Record reviewed 1/14/26 does not include evidence of the facility obtaining R6's PASRR Level II after being diagnosed with Schizophrenia on 1/21/25. On 1/14/25 at 9:30 AM, V10 (Admissions Coordinator) stated she is the person who handles resident PASARR screens on admission and with updates. V10 verified that she does the PASARR screens, but she is not in the building full time because her office is located in a sister facility. V10 stated I or the facility's social worker (V8, Social Service Director) should be checking over PASARR level one screens to make sure that the diagnoses are accurate and if a new one is added, then facility staff have to tell us so that we can have residents re-screened. V10 confirmed that any diagnoses of a resident's mental illness should be included on the level one and level two screenings so that accurate support services can be obtained. On 1/14/26 at 10:02 AM, V1/Administrator in Training stated that R6 had the diagnosis of Schizophrenia before 1/21/25 but it was not identified in R6's chart until an audit was done after a change of ownership. The diagnosis was documented on 1/21/25 on R6's records and a new PASRR II was not requested but should have been.</p> | | |

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| 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) | | |
| <p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and Record Review, the facility failed to ensure residents with Mental Illness diagnoses were provided the required level two PASARR (Pre-admission Screening and Resident Review) upon admission to the facility for two of five residents (R2, R43) reviewed with PASARR in the sample of 28. Findings include: The facility's Social Service-Coordination with PASRR program policy, dated 2/2/24, documents This facility coordinates with the preadmission screening and resident review (PASARR) program to ensure that residents are appropriately placed in nursing homes for long-term care. All individuals with a mental disorder or intellectual disability who apply for admission to this facility will be screened in accordance with the state's Medicaid rules for screening. Recommendations, such as specialized services, from a PASRR level two determination and or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care.</p> <p>1. R43's current Care Plan, dated 5/27/25, documents R43 was admitted to the facility on [DATE] and has diagnoses of Psychoactive Substance Abuse, Alcohol Dependence, Major Depressive Disorder, Mood Disorder and Schizoaffective Disorder.</p> <p>R43's current medical record does not document a level two PASARR screen.</p> <p>R43's PASRR level one screen, dated 4/29/22, does not document R43's substance abuse-related disorders or a diagnosis of schizoaffective disorder. This same screening documents a level two PASRR screen is not required due to no diagnoses of serious mental illness, intellectual disability or related concerns.</p> <p>2. R2's current Care Plan, dated 6/4/2025, documents an admission date of 5/22/2024 and diagnoses of Schizophrenia, Bipolar Disorder, Insomnia due to other mental disorder, Paraphilia, Generalized Anxiety Disorder, Unspecified Intellectual disabilities, and Cognitive Communication Deficit.</p> <p>R2's level one PASARR, dated 3/21/2022, documents R2 was referred to have a level two PASARR screen completed.</p> <p>R2's current medical record does not contain documentation that a level two PASARR screen was ever completed.</p> <p>On 1/14/25 at 9:30 AM, V10 (Admissions Coordinator) stated she is the person who handles resident PASARR screens on admission and with updates. V10 stated I am not sure why (R2) does not have a level two PASARR in his medical record. I tried to see it on the website and could not. When the level one and level two screens are done, they should be kept in the resident's electronic medical record, and we do not have one for R2. I was not made aware that R43 had a diagnosis of schizoaffective disorder, and I did not realize that it was not present on her level one PASARR screening. V10 verified that R43 should have been referred to have a level two screen completed and that she has not had one and that any diagnoses of a resident's mental illness should be included on the level one and level two screenings so that accurate support services can be obtained.</p> | | |