Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002190	A. BUILDING: ______ B. WING ______	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE NURSING & REHAB CTR	1635 EAST 154TH STREET DOLTON, IL 60419

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S 000	Initial Comments Complaint Investigation: 1996632/IL115577	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b) 300.1210d)3)6) 300.1220 b)2) 300.3240a)f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	Attachment A Statement of Licensure Violations	

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of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

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2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.
f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements wer not met as evidenced by:

Based on interview and record review, the facility failed to ensure that staff protected a resident that was assessed as a high risk for physical abuse, failed to notify a physician regarding an increase in aggressive/delusional behaviors, failed to notify the psychiatrist after a resident to resident physical assault, failed to ensure that a resident was closely monitored after a psychotropic medication was discontinued and failed to ensure that staff provided supervision per facility policy for two residents (R3, R4) of five residents reviewed for abuse. These failures resulted in

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R3's physical assault on R4 which required an emergent transfer to a hospital with the following injuries: facial trauma, one centimeter (cm) laceration to right cheek that required two sutures, a two centimeter laceration to right index finger which required four sutures, a transverse fracture of right fourth finger and a fractured left wrist.

Findings include:

R3's Resident Face Sheet documents a medical diagnosis of Schizophrenia. R3 is 65 years old.

R3's medical record documents a history of three incidents of resident to resident physical altercations in which R3 was the aggressor. Two of the incidents involved R3's former room mates: 4/21/19: R3 hit roommate. 5/2/19: R3 involved in a physical altercation in lunch room and hit peer with a lunch tray and 5/6/19: R3 physically assaulted roommate. It is documented on a reportable abuse form that on 5/6/19, R3's roommate was standing on R3's side of the room. R3 physically assaulted her roommate and caused multiple bruises/scratches. R3's Minimum Data Set (MDS) dated 4/23/19 documented that R3 was Cognitively Intact.

R3's Care Plan dated 5/1/19 documents: (R3) is at risk for adverse consequences related to receiving antipsychotic medication for treatment of schizophrenia, psychotic disorder. Approach: Assess if (R3's) behavioral symptoms present a danger to herself and/or others. Intervene as needed. Monitor (R3's) behavior and response to medication.
R3's Care Plan dated 4/24/19 documents: (R3) has verbal and physical behavioral symptoms directed towards others (e.g., threatening others,

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screaming at others, cursing and striking at others). Approach: Assess whether (R3's) behavior endangers herself and/or others. Intervene if necessary.

R4 is R3's roommate. R4's Resident Face Sheet documents a medical diagnosis of Alzheimer's Disease, Unspecified Dementia with Behavioral Disturbance, Schizoaffective Disorder and Schizophrenia with psychotic features. R4 is 99 years old.

R4's MDS dated 6/20/19 documents in the Cognitive Patterns section that R4 is rarely/never understood.

R4's Abuse Risk Review dated 7/19/19 documents that R4 is at risk for Physical abuse due to Serious Mental Illness and Confusion/disorientation.

R4's Care Plan dated 7/10/19 documents: R4 is a suitable for risk of abuse and neglect due to her diagnosis of Dementia. Approach: (R4) will be monitored closely by staff. (R4) will be reminded and redirected to lower risk of harm.

On 9/11/19 at 1:44pm, V6 (Social Services Supervisor) stated, "The reason (R3) got into it with prior roommates was because they were loud and had a lot of visitors. That's why we paired her with (R4) who has no visitors and is quiet. I didn't think (R3) would be a threat to (R4)."

On 9/11/19 at 10:45am, V5 (LPN-Licensed Practical Nurse) indicated that R3 was moved into R4's room after the physical altercation with a room mate on 5/6/19. R3's Resident Census sheet documents that she was moved into R4's

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room on 5/8/19.

R4's medical record documents that on 9/8/19, R4 was physically assaulted by R3 and that it was unwitnessed. R4's progress note authored by V5 and dated 9/8/19 at 9:42pm documents: "Nurse was called by CNA (Certified Nurse Assistant) stating that (R4) was on the floor. Writer immediately went to room and notice(d) resident lying on left side by (R3's) bed. Resident was examined and observed with blood and multiple purple/reddish discoloration on left side on back, buttock, right shoulder, left arm to forearm, left hand swollen. Laceration on right cheek, right index finger and by right side of eye. Resident was placed back in bed in a comfortable position, (R3) was asked to leave room so that (R4) can be properly assessed and cared for. Upon (R3) getting out of bed, staff noted a belt with blood stains on it."

R3's progress note authored by V5 and dated 9/8/19 at 10:20pm documents, in part: "Writer noticed that (R4) had bruises and red marks on her body, writer asked (R3) what happened. Writer suspected that (R3) have something to do with it."

R4's hospital record dated 9/9/19 documents that the following treatments were performed as a result of the injuries: Laceration repair to right cheek. One centimeter (cm) in length and required two sutures.
Laceration repair to right index finger. Two cm in length and required four sutures.
Computerized Radiography of both hands revealed: IMPRESSION: Transverse fracture of the right fourth metatarsal diaphysis (finger).
Avulsion fracture of left ulnar styloid (wrist).
This hospital record documents: "99 year old

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female presents to the ED (Emergency Department) from nursing home for assault. Patient has clear evidence of head trauma, laceration to face and laceration to finger as well as (bruising) of (both) hands and shoulders as well as ankles and several other places of the upper and lower extremities.

R3's MDS dated 9/4/19 documents that R3 was Cognitively Intact at the time of the physical assault on R4.

R3's progress notes document the following:
8/13/19: 3. Schizophrenia-Advised to see the psychiatrist for advise.
8/27/19: (R3) can be paranoid at times and says that she is German speaking what she perceives to be the German language derived from diagnosis of Schizophrenia.
9/3/19: Resident was met due to her presenting with delusional statements that she was born in Germany and that she was married to the prince of Germany.
9/3/19: (R3) also exhibits symptoms of mood distress as evidenced by scoring a 6 of 27 on the PHQ-9 (Patient Health Questionnaire for Depression), indicating mild depression. (R3) has exhibited increased agitation and verbal aggression towards staff when redirected or when she doesn't understand. Clinical services will continue to monitor for changes in behavior.
9/7/19 12:45pm: Resident exhibited verbally aggressive behavior towards staff once she was observed placing an outgoing call to facility from smokehouse phone.
9/7/19: 1:33pm: Resident was engaged in a verbal altercation in dining room following lunch with peer.
On 9/8/19, the physical assault incident with R4 occurred.

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The facility's surveillance video was reviewed with V1 (Administrator) on 9/12/19 at 12:40pm. It was noted that V4 (CNA) brought R4 into her room at 6:24pm. From 6:24pm to 8:52pm, no staff members entered R3 and R4's room to monitor them. At 8:52pm, V4 entered the room and found R4 on the floor.

According to the facility assignment dated 9/8/19 evening shift, V4 (CNA) and V5 (LPN) were assigned as primary nurses for R3 and R4. Their time cards denote that V4 and V5 both clocked out for lunch at 8:26pm and 8:27pm. V9 (LPN), V11 (LPN), V17 (CNA) and V18 (CNA) were the other staff members scheduled on that shift and on that wing. All staff stated that V4 and V5 did not let them know that they were going on break and as a result, R3 and R4 were not monitored.

R4's Care Plan dated 7/10/19 documents: R4 is a suitable for risk of abuse and neglect due to her diagnosis of Dementia. Approach: (R4) will be monitored closely by staff. (R4) will be reminded and redirected to lower risk of harm.

On 9/12/19 at 1:23pm, V2 (DON-Director of Nursing) stated, "The assignment should be covered if both nurse/CNA of the assignment take break together. They should be letting all the other team members know that they are taking a break so that there is no break in resident supervision. Rounding on residents should be every one hour, if they need close monitoring, like the hospital."

It is documented that on 8/13/19, R3's physician recommended to be seen by psychiatrist. On 8/27/19, a Psychotherapy Progress Note documented that R3 refused to begin individual

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therapy and refused to participate in evaluation for individual therapy.

On 9/11/19 at 10:45am, V5 (LPN) stated, "(R3) was having outbursts leading up to this incident (9/8/19). But she usually had those every day."

On 9/11/19 at 2:28pm, V23 (Social Services) stated, "I noticed that in the last couple of weeks that (R3's) delusions and verbal aggressions were increasing. There was definitely a change in her demeanor the last couple of weeks. There was a change in her verbal aggression from what her norm was. I know she was having delusions."

On 9/11/19 at 1:44pm, V6 (Social Services Supervisor) stated, "Just last week, (R3) started to spark again with verbal aggressions towards staff and peers." On 9/11/19 at 2:27pm, V6 indicated that if R3 felt like something was going on, then she may have requested to see the psychologist. V6 stated, "Psychotherapy is referred for increased behaviors, after an incident or if deep depression."

V6 stated that R3 was care planned to go to anger management therapy and symptom management groups due to the conflicts with peers. V6 was only able to provide one anger management session sign in sheet that had R3's signature for attendance dated 7/27/19. V6 indicated that when R3 refused psychotherapy sessions and anger management groups, there was no alternative plan for her to learn how to deal with her anger.

With R3's increasing verbal aggressions, increasing delusions and refusal to have a psychotherapy evaluation, there is no documentation of consistent behavior

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monitoring/tracking or physician notification regarding the behaviors.

R3's Medication Administration Record dated September 2019 documents that R3 was taking Quetiapine 25 milligrams (mg) three times a day for a total of 75 mg. On 9/6/19, R3's Quetiapine dosage was increased to 50 mg twice a day for a total of 100 mg for Schizophrenia. On 9/6/19, it is also documented that R3's Risperidone 0.5 mg (for Schizophrenia) twice a day was discontinued on 9/6/19.
R3's MAR documents that R3 missed a Quetiapine 50 mg dose at 5:00pm on 9/8/19.
R3's MAR documents that R3 missed Risperidone 0.5 mg 9:00am doses on 9/4/19, 9/5/19 and 9/6/19.
There is no documentation in R3's medical record that the physician or psychiatrist were notified regarding the missed doses.

On 9/12/19 at 1:44pm, V22 (Psychiatrist) stated, "We saw her on Friday 9/6/19. She was refusing Risperidone order and I ordered for there to be an increase in the Seroquel medication. She was increased from 25 mg three times day to Seroquel 50 mg twice a day. On Sunday, she beat someone up and no one from the facility called me. I did not get any phone call on Saturday or Sunday. If her aggressive behavior was increasing, I should have been notified. I was not called until Monday 9/9/19 by (V21-Quality Assurance Nurse) and I sent (R3) to the hospital right away. She should have been sent on Sunday after the incident. If agitation, I would have ordered a PRN (as needed). I would do something. If there was adequate monitoring and supervision, then this could have been avoided. Because I changed her medications, she should have been closely monitored. She refused the

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Risperidone for 1-2 days. She was already on the long acting Consta which stays In the system for 2 weeks. Really, if someone called me about her increasing aggression on Saturday, I would have given PRN medication, placed her on 1:1 monitoring or sent her to the hospital. Then, this won't happen." V22 confirmed that she was not notified regarding R3's missed doses or refusal to take medications.

R3's medical record does not document that V22 was notified of the physical assault on R4. R3's progress notes document that R3 was allowed to remain in the facility until 9/9/19 at 1:34pm at which time she was transferred for a psychiatric evaluation.

On 9/12/19 at 10:33am, V21 (QA-Quality Assurance Nurse) indicated that ideally she talks to the psychiatric team about resident behaviors and if medications should be increased, decreased or changed. V21 stated that it is not done on a consistent basis. V21 stated, "The nurses will chart behaviors in the progress notes. There is no behavior tracking log. I see that the nurses are putting behavior notes in but not every shift and not consistently. I agree that we do not track psychotropic medications and behaviors consistently."

A facility policy dated August 2008 and titled, "Routine Resident Checks" documents: Routine resident checks shall be made to assure that the resident's safety and well being are maintained. 1.) To ensure the safety and well being of our residents, a resident check will be made at least every two (2) hours throughout each 24-hour shift by nursing service personnel.

A facility policy dated February 2014 and titled,

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"Psychotropic Medication Policy" documents: Policy: To establish the process for monitoring the use of and the reduction of doses of psychotropic medications without compromising the resident's health and safety, ability to function appropriately, or the safety of others. Procedural Specifications: 5. Documentation of behaviors and conditions requiring the use of these medications must be done on a routine basis including resident response to the medication.

A facility policy dated November, 2016 and titled, "Notification of Resident Change in Condition Policy" documents: Policy: It is the policy of this facility to promptly notify the resident, their legal representative(s) and attending physicians of changes in the resident's health condition. Standards: 1b. A significant change in the resident's physical, mental or psychosocial status i.e. deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complication. c. A need to alter treatment significantly i.e. a need to discontinue an existing form of treatment due to adverse consequences or to begin a new form of treatment.

A facility policy dated August 2008 and titled, "Behavior Assessment and Monitoring" documents: Monitoring: 1. If the resident is being treated for problematic behavior or mood, the staff and physician will document ongoing observations. 2. The staff will document (either in progress notes, behavior assessment forms, or other comparable approaches) information about specific problem behaviors.

A facility policy dated February 2017 and titled, "Abuse Prevention Policy" documents: This facility affirms the right of our residents to be free from abuse, neglect, exploitation,

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misappropriation of property or mistreatment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of abuse, neglect, exploitation, misappropriation of property and mistreatment of residents. VI: Protection of Residents: The facility will take steps to prevent potential abuse while the investigation is underway. Residents who allegedly abused another resident shall be immediately evaluated to determine the most suitable therapy, care approaches, and placement, considering his or her safety, as well as the safety of other residents and employees of the facility.

(A)