

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2020</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 EAST 154TH STREET DOLTON, IL 60419</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Initial Comments  Facility Reported Incident Investigation of 4/16/2020/IL125814	S 000		
S9999	Final Observations  Statement of Licensure Violation:  300.610a) 300.1210b) 300.1210d)6) 300.1220b)3) 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 300.1210 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	S9999	<b>Attachment A</b> <b>Statement of Licensure Violations</b>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2020</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 EAST 154TH STREET DOLTON, IL 60419</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:</p> <p>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:</p> <p>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.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2020</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 EAST 154TH STREET DOLTON, IL 60419</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 2</p> <p>or agent of a facility shall not abuse or neglect a resident</p> <p>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)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide a safe environment by placing a resident with a history of aggressive behaviors in a room with a resident who was at risk for being abused. This failure resulted in R2's emergent transfer to a hospital with the following injuries of :a fracture of bilateral nasal bones with soft tissue swelling and a left frontal scalp hematoma after an incident with roommate (R1).</p> <p>Findings include:</p> <p>R1 is 63 years old with diagnoses of (but not limited to) Schizoaffective Disorder, Bipolar Disorder, Extrapyramidal and Movement Disorder and Major Depressive Disorder.</p> <p>R1 has documented history of physically aggressive behaviors, dating back from 2017, including: 7/17/19 hit peer in the eye;</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2020</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 EAST 154TH STREET DOLTON, IL 60419</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>1/19/20 pulled peers hair; 2/19/20 verbally aggressive.</p> <p>R1's aggressive documented as at risk; "may become physically aggressive towards others due to impulsivity ..."</p> <p>R2 was 81 years old, with diagnoses of (but not limited to) Malignant Neoplasm of Larynx, Unspecified, Unspecified Dementia Without Behavioral Disturbance, Major Depressive Disorder, Single Episode, Schizophrenia, Unspecified.</p> <p>R2 was put on Hospice Care starting from 11/19/2020 up to time of passing on 6/3/2020.</p> <p>R2 was assessed as at risk for Abuse. Aggressive Risk review indicated that R2 has history of verbal aggression but has not exhibited such behavior recently.</p> <p>Progress notes dated 4/16/2020 documented that R1 struck R2 three times in the face. R2 was sent to the hospital and came back to the facility with documented injuries of Fracture of the bilateral nasal bones with perinasal soft tissue swelling, Left frontal hematoma. At the time of this incident, R1 and R2 were roommates.</p> <p>On 8/19/2020 at 2:09PM, V1 (Administrator) said that the BIMS (Brief Interview for Mental Status) is the basis of roommate selection. The facility also takes in consideration the history of aggressive behavior.</p> <p>R1's BIMS' score at the time she was transferred to R2's room was 15, intact cognition, and R2 was 11 moderately impaired.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2020</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 EAST 154TH STREET DOLTON, IL 60419</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>R1's care plan approaches for R1's Behavior were: Anticipate needs in order to decrease behavioral symptoms. Social services to assess R1's aggression. Staff will separate resident from others as needed. R1 will be monitored by staff. R1 will be reminded and redirected to lower risk of harm by staff. R1 will be reminded that staff is available 24/7 to assist at all times to provide emotional support and whatever support she needs. Redirect R1 during periods of increased agitation. R1 to refer to psychologist/psychiatrist for behavior management as needed.</p> <p>On 8/20/2020 at 10:38 AM, V11 (Social Services Director) said that R1's treatment plan should have been more individualized. Not just a "cookie cutter type". The approaches should have been more specific and the facility is working on training staff. V11 also said that R1 has unpredictable behavior, with incongruent affect, and does not show signs and symptoms leading to aggressive behavior and knowing these facts, does not think it was safe for R1 and R2 to be in the same room.</p> <p>Abuse Prevention Policy and Prevention state in part; The facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriations of property and mistreatments by anyone including, but not limited to facility staff ... ..or any other individuals.</p> <p>Care Plans Policy dated 4/2015 state in part; An individualized Comprehensive Care Plan that includes measurable objectives and timetable to meet the resident's medical, nursing mental and/ or psychological needs is developed for each resident. 6. Care plans are revised as changes in the resident's condition dictates.</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6002190</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/20/2020</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>COUNTRYSIDE NURSING &amp; REHAB CTR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1635 EAST 154TH STREET DOLTON, IL 60419</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999 Continued From page 5

(A)

S9999