Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
IL6005631		B. WING		C 06/03/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COUNTR	YVIEW CARE CENTE	K-MACOMB	T GRANT \$1 , IL 61455	REET		
(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		S 000			
	Facility Reported Inc	cident #134296		· a		
S9999	Final Observations		S9999			
	Statement of Licens	ure Violations:		*		
	300.610a)	9	**			
× .	300.3210a) 300.3240a)e)					
	procedures governing facility. The written be formulated by a formulated by a formulated consisting administrator, the admedical advisory coof nursing and other	have written policies and ng all services provided by the policies and procedures shall Resident Care Policy				
	The written policies the facility and shall by this committee, d and dated minutes of	shall be followed in operating be reviewed at least annually ocumented by written, signed of the meeting.	-			
	rights, benefits, or p	shall be deprived of any rivileges guaranteed by law s a resident of a facility.				
	employee or agent on neglect a resident. (Act) e) Employee as	ensee, administrator, of a facility shall not abuse or (A, B) (Section 2-107 of the s perpetrator of abuse. When		Attachment A Statement of Licensure Violations	1 100	
	an investigation of a	report of suspected abuse of				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:					
			ļ				
		IL6005631	B. WING			C 0 3/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
COUNTS	OVICIAL CARE CENTE	400 WES	T GRANT S	TREET			
COUNT	RYVIEW CARE CENTE	R-MACUMB	, IL 61455	•			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	OPPECTION		
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH	E APPROPRIATE	DATE	
	·			DEFICIENCY	<u> </u>		
S9999	9 Continued From page 1		S9999]	
	a recident indicator	, based upon credible					
i.	evidence that an ev	nployee of a long-term care					
	facility is the perpet	rator of the abuse, that					
S=C 1.	employee shall imm	rediately be barred from any		31			
	further contact with	residents of the facility,					
	pending the outcom	e of any further investigation,					
	prosecution or disci	plinary action against the					
	employee. (Section	3-611 of the Act).					
		•	171				
	These Regulations	are not met as evidenced by:					
	December to the state of the						
	based on interview	and record review, the facility					
	verbal and mental a	sident (R1) was free from buse and failed to recognize					
	these alienations as	abuse for one of three					
	residents (R1) review	wed for abuse in the sample			}		
. [of three. These failu	res resulted in R1 sustaining					
	verbal and mental a	buse from a staff member		·		1	
	(V8/Certified Nursing	g Assistant), resulting in an					
	escalation of R1's be	ehaviors.				- 1	
				-			
	Findings include:						
ĺ	The feelible Abuse I	Drawantian Drawan unit					
1	dated 04/2021 door	Prevention Program policy ments, "This facility affirms		Į.			
	the right of our resid	ents to be free from abuse,				· i	
	neglect misangropri	iation of resident property,				i	
	and exploitation. Ab	buse: Abuse is the willful					
ľ	infliction of injury, un	reasonable confinement,				-	
	intimidation, or punis	shment with resulting physical				i	
	harm, pain, or menta	al anguish. Verbal abuse is		* + 1			
	the use of oral, writte	en, or gestured language that					
	willfully includes disp	paraging and derogatory					
, [-	terms towards reside	ents or families, or within their					
	nearing distance reg	ardless of their age, ability to					
	comprehend, or disa	ibility. Example of verbal					
		re not limited to, threats of					
	marm, or saying thing	gs to frighten a resident.					

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FORM APPROVED Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING IL6005631 06/03/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 WEST GRANT STREET COUNTRYVIEW CARE CENTER-MACOMB MACOMB, IL 61455 SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) S9999 Continued From page 2 S9999 Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a residents, harassment, humiliation. and threats of punishment or deprivation." R1's MDS (Minimum Data Set) Assessment dated 3-24-21 documents R1 has no behaviors. requires assistance of one person physical assistance for eating and toileting, and has the diagnoses of dementia, borderline personality disorder, anxiety, depression, and bipolar disorder. R1's (State Agency) Notification Reports dated 5-19-21 and signed by V1 (Administrator) documents, "Staff (V4/MDS/Minimum Data Set Coordinator) and (V5/Registered Dietician) reported other staff member (V8/CNA/Certified Nursing Assistant) being verbally inappropriate in the dining area. Investigation concludes no type of abuse of any resident occurred." The facility's Abuse Inservice Log dated 5-10-21 and signed by V1 (Administrator) documents V8 was trained on the facility's Abuse Policy on 5-10-21. On 6-1-21 at 8:45 AM, R1 stated, "(On 5-19-21) I was in the dining room and a black girl would not take me to the bathroom. I had to pee. I got upset and threw my plate. The girl started velling at me and made me go to my room. She did not take me to the bathroom." On 6-1-21 at 9:15 AM V5 (Registered Dietician) stated, "On 5-19-21, I was in the business office and heard loud screaming in the dining room.

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(R1) was sitting in her wheelchair in the dining

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worse. (V8) seemed to be inappropriate with residents at times and would be sassy."

On 6-1-21 at 11:30 AM V8 (CNA) stated, "That

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

NAME OF PROVIDER OR SUPPLIER COUNTRYVIEW CARE CENTER-MACOMB (X4) D PREFIX TAG (X4) D PREFIX TAG COUNTRYVIEW CARE CENTER-MACOMB (X4) D PREFIX TAG COUNTRYVIEW CARE CENTER-MACOMB (X4) D PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S9999 Continued From page 5 (V3/Regional Supervisor) instructed me document the allegations as not being abuse so that the facility does not get in trouble with (State agency). (V8) yelling at (R1) and threatening (R1) with going to jail is definitely abuse." (B)	(X3) DATE SURVEY COMPLETED C 06/03/2021	
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(B)		
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