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 12/03/2021

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 Facility Reported Incident of October 19, 2021 IL140054	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 d)1) 300.1210 d)3) 300.4040 a)1) 300.4040 a)5) 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	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1	S9999		

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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
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.

Section 300.4040 General Requirements for Facilities Subject to Subpart S
a) The psychiatric rehabilitation services program of the facility shall provide the following services as needed by facility residents under Subpart S:
1) 24 hours of continuous supervision, support and therapeutic interventions
5) Crisis services

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to follow their medication administration practice to ensure medications are swallowed after administering them for 1 of 3 residents (R1) reviewed medication administration, and failed to provide psychosocial interventions after a resident verbalized feeling of being depressed. This affected 1 of 3 residents (R1) reviewed for

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S9999	Continued From page 2 changes in mood and behaviors These failures resulted in R1 informing the nurse R1 was feeling suicidal and had self-administered approximately 20 pills. R1 was assessed and treated with Narcan for drug overdose and was transported to the local hospital for further treatment. Findings include: R1's facility face sheet shows R1 has diagnosis of PTSD (Post-Traumatic Stress Disorder), psychosis not due to substance or known physiological condition, major depressive disorder recurrent severe with psychotic symptoms, suicidal ideations, hypertension, benign prostatic hyperplasia, weakness and umbilical hernia. R1's Nursing Facility Placement PAS/MH level 2 notice of determination, dated 1/08/2020, shows, in part, the following information is a summary of the findings of your pre-admission screen: special services; professional observation (MD/RN) for medication monitoring, adjustment and stabilization, instrumental activities of daily living training/ reinforcement, mental health rehabilitation activities, illness self-management, incentive program to improve participation in treatments, community re-integration activities, and substance use/abuse management. R1 PAS/ Placement Assessment Summary, dated 1/08/2021, shows "mental status and presenting behaviors- confused, impaired memory, confused, limited insight, delusional thought process, average intelligence, patient presented unkempt, his voice was appropriate his gait was steady but walked slowly, he was cooperative and at times made inappropriate comments towards writer. He is disorganized in	S9999		

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S9999	Continued From page 3 his thinking, report that he came to the hospital because people are corrupt, he then began talking about climate change and writing down license plates, he was not orient to the day, even when writer showed him her watch as the date, he was sure he was watching football the day before, he has limited insight to his illness and demonstrate poor judgement by not taking his prescribed medication. Patient is a poor historian. Diagnostic impression- bipolar disorder, current episode manic severe with psychotic features. History of antisocial/ maladaptive risk behavior assessments - poor judgement placing self and others at risk, 2019 patient report he has not been complaint with medications and denied having a psychiatrist in the community. Self-injurious behaviors in 2019, came to hospital with plan to cut his wrists. Self-injurious behaviors in 2018, report of suicidal attempt where he drank 409 or lighter fluid, it is unclear which. Self-injurious behaviors in 2017, report of suicidal attempt, it is unclear what he did in this attempt. Self-injurious behaviors in 2014, report of suicidal attempt, it is unclear what he did during this attempt. Patient is not on the registered sex offender website. He has a history of suicide attempts. He came to hospital reporting suicidal ideations with a plan. He has not been compliant with medications or outpatient treatment which demonstrates poor judgements placing self at risk with his history of suicide attempts. In the past he had contact with criminal justice as a 15 year old in 1999." R1's MDS (Minimum Data Set), dated 10/4/21, shows BIMS (Brief Interview for Mental Status) score of 13 (cognitively aware), disorganized thinking that fluctuates, mood severity score is 15 (moderately severe symptoms of mood).	S9999		

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S9999	Continued From page 4	S9999		

Review of R1 POS- (Physician Order Sheet) for October 2021 shows there is no order documented for R1 to self-administer medication and take 1.5 tablets of Seroquel for sleeping.

R1's care plan, dated 11/2/21, shows, in part, "behavioral symptoms I am an adult with dx (diagnosis) of major depression, recurrent with psychotic features, including h/o suicidal ideations (SI). I am aware that I have h/o (history of) attempting suicide, including most recently being hospitalized for endorsing SI with attempt AEB (as evidence by) swallowing pills (10/19/2021). I am also aware that I was hospitalized prior to admission for cutting my wrist and digesting foreign substance (2019). Goal is, I will discuss triggers which lead to suicidal thoughts w/ appropriate staff in therapeutic and non-judgmental setting by next review. Staff will discuss different coping mechanisms which have worked in the past, and work with R1 to establish a safety contract to assist R1 with processing through his feelings. Staff will monitor resident for changes in moods/behaviors including regular psychosocial well-being checks when increased bxs (behavior) are observed. Staff will provide safe space for R1 to ventilate/process his feelings in safe/non-judgmental space; counsel Robert regarding positive coping skills."

R1's care plan, dated 11/02/21, shows, in-part, "(R1) exhibits s/s (signs and symptoms) of mood distress related SMI (Severe Mental Illness) dx (diagnosis) and Dementia, AEB scoring 14 of 27 on the PHQ-9. Symptoms are manifested by h/o endorsing SI (suicidal ideations) w/ previous attempt of swallowing pills, isolating to self and room, and participating in independent activities, becoming physically/verbally aggressive, internal preoccupation and responding to internal stimuli

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S9999	Continued From page 5 not based in reality. (R1) will verbalize the thoughts and feelings that contribute to remaining depressed, by next review. Staff will discuss the resident's situation with the psychiatrist and the IDT. Staff will provide counseling/support sessions throughout week; specify group, individual, PRN (as needed) treatment. Staff will use open-ended questions during counseling sessions such as, "How can you take advantage of your strength?" "How can you take control over life and improve your day-to-day functioning?"" R1 ambulance report, dated 10/19/21, shows, in-part, "primary impression suicide attempt, signs and symptoms- behavior/emotional state suicidal ideations, injury-intentional self-harm intentional self-harm by other means, nursing home, 10/19/21, additional injury-attempted suicide. (Ambulance Company) ALS ambulance 8 was dispatched to a nursing home for the suicide attempt. Upon arrival, patient was found to be a 62 year old male alert and oriented x4, GCS 15, sitting in couch. Patient was lethargic and slow to respond. Patient stated he took 20 Seroquel pills 3 hours ago. Patient stated he's been hiding and collecting them. Patient stated he tried to kill himself for personal reasons. Patient was extremity carried and placed on stretcher. Patient was secured and transported to ambulance. An ALS assessment and set of vital signs were obtained. Glucose was obtained. Pupils were noted to be constricted. 3 lead showed sinus tachycardia. 2 IV attempts were unsuccessfully. 1 IV attempt was successful in the right hand. Narcan 2mg was given and flushed successfully. Patient's Blood pressure was low so a fluid bolus was initiated at a TKO rate. Patient was placed on 2lpm via nasal cannula on oxygen to keep oxygen saturation above 95%. Patient denies any headaches, dizziness, nausea/vomiting, or blurry	S9999		

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S9999	Continued From page 6	S9999		

vision at this time. Enroute, observable vital signs remained unchanged. Patient remained alert in position of comfort with no complaints. Report was called into receiving hospital and no orders were given. At destination, patient was transported inside via stretcher and taken to room 9. Patient was transferred over to stretcher using sheet method. Bedside report was given. Patient care was transferred over to RN. All times approximate." End of report.

Facility final report sent to IDPH on 10/27/21 shows, in-part, "description of occurrence, (R1) verbalize feelings suicidal thoughts and during assessment he admitted to swallowing pills to social service. (R1) was on 1:1 with staff for safety monitoring as 911 was called. (R1) was transferred to hospital for acute evaluation, alert and verbal while leaving facility. Occurrence resolution, upon investigation, (R1) was interviewed and despite supportive counseling and engagement with family, due to the recent loss of his mother, he still felt sad at times. (R1) stated that he was being suicidal but did thought the medication would help him sleep. (R1's) room was inventoried and a plastic zip lock bag was discovered with 3 half melted pills. Nursing staff was unable to identify medications due to their deteriorated condition. (R1) remains hospitalized at this time and the writer was unable to obtain updates. (R1's) care plan will be reviewed upon readmission and assessments will be on-going to ensure appropriate group placement."

R1 psychiatric evaluation from the hospital (second admitting hospital), dated 10/27/21, shows, in-part, "(R1) is a 62 year old male with long standing history of poorly controlled bipolar disorder along with a lot of personality disorders traits. He's a resident of nursing home and he

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S9999	Continued From page 7	S9999		

was transferred to the in-patient setting after they described him as being very depressed, disorganized, confused and psychotic. Apparently he been non- compliant with his medication for some period of time and he began to endorse active suicidal ideations with possible a plan to overdose on medication. He wasn't clear about his comments. In terms of his mood, he continues to experience worsening symptoms of depression. He continues to be very irritable, restless and confrontational at times. At times, he continues to be somewhat more belligerent. He also endorses active suicidal ideations and visual hallucinations."

R1 progress note, dated 10/19/21 at 3:45p.m, shows, in-part, "Resident presented this morning at 8:45a.m with suicidal ideations, stated "I took some pills" placed on 1:1 observation while physician being paged. While on 1:1 resident had a change LOC, became lethargic, diaphoretic and non-responsive. Writer phoned 911 and two EMT workers as well as local police arrive 0855. Face sheet/POC given to emergency workers and resident was taken to hospital ER. 98.0 70 18 112/70. On 10/20/21 at 3:12a.m resident admitted to hospital with dx (diagnosis) of drug overdose."

R1 progress notes, dated 10/19/21 at 9:00a.m, documented by V12 (PRSC- Psychiatric Rehab Support Counselor) shows, in-part, behavior note: "R1 approached staff endorsing SI (suicidal Ideation). R1was provided safe space to ventilate/process his feelings regarding incident. (R1) presents with blunted affect and depressed mood, stating he feels "suicidal and swallowed medications." Nursing made aware; 9-1-1 Emergency services were called. R1 was placed on 1:1 monitoring until EMTs arrived. Staff spoke w/ Officer who presented PRSC with case

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S9999	Continued From page 8 #D21-17522, resident will be transported to hospital. Clinical Services will continue to monitor. At 3:45p.m resident presented this morning at 8:45a.m with suicidal ideations, stated "I took some pills" placed on 1:1 observation while physician being paged. While on 1:1 resident had a change LOC, became lethargic, diaphoretic and non-responsive. Writer phoned 911 and two EMT workers as well as local police arrive 8:55. Face sheet/POC given to emergency workers and resident was taken to hospital ER. 98.0 70 18 112/70. On 10/20/21 at 3:12a.m resident admitted to hospital with dx (diagnosis) of drug overdose." V13's (Nurse) employee statement, dated 10/19/21, shows, in-part, "At 8:45a.m resident (R1) told writer that he was suicidal, writer asked resident if he had a plan, resident stated "I took some pills". Writer took resident to Counselor's office for one to one observation. While writer was attempting to contact resident's psychiatrist, resident had a change in his level of consciousness. Writer then called 911." V12 (PRSC) employee statement, dated 10/19/21, shows, in-part, "During smoke break (8am) (R1) approached stating he was feeling depressed, resident presented with flat affect and depressed mood appearing to respond to internal stimuli, not based in reality. At this time, I was monitoring smoke break and encouraged resident to speak with nurse until I could finish. R1 approached this writer again stating that he felt suicidal; at that this time I asked that nurse to monitor him for a few minutes. When I finished with smoke break I was informed by resident that he'd swallowed sleeping pills. I informed the nurse to follow appropriate protocol and contact his psych MD (medical doctor) to receive orders. (R1) was interviewed and monitored in SS (social	S9999		

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S9999	Continued From page 9 service) office. During monitoring resident began to exhibit noticeable reactions, unable to keep his head up, appearing to fall asleep or potentially lose consciousness. Nurse was made aware and asked to call 911 emergency services. Staff performed interventions to keep resident alert until EMTs (Emergency Medical Technician) arrived and transported to nearest hospital." On 11/18/21 at 2:15p.m, R1 was observed sitting on R1's bed, alert and orient to person, place, and time. R1 said R1 had been feeling depressed because R1's mother had recently passed away, R1 was feeling suicidal, and so R1 took about 20 pills R1 saved up in a plastic bag. R1 said R1 would keep the pills in the bag under his mattress. R1 said R1 obtained the pills by not swallowing them, and then saving them inside a plastic bag for consumption at a later time. R1 said these were R1's sleeping pills; R1 would usually keep the pills so that R1 could take 1.5 pills to help him sleep. R1 was asked does the nurse watch you take your medicine, does the nurse check your mouth after you take your medication? R1 said, "They do now but not before." On 11/19/21 at 8:34a.m, V5 (Nurse) was observed during medication administration, V5 was observed gathering medication, placing medication in a clear plastic cup. V5 asked residents to state their names. V5 gave the medication to the residents with water; residents observed putting the medication in thier mouth, and then drinking water. When the resident was done swallowing the water and pills, V5 asked each resident to open their mouth and stick out their tongue. V5 said V5 does that for all the residents because some residents with cheek medication (not swallow medication but hold it in	S9999		

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S9999	Continued From page 10 their mouth). On 11/19/21 at 10:01a.m, V13 (Nurse) said on 10/14/21 around 8:40a.m, R1 approached V13 and said R1 was suicidal. V13 said V13 asked R1 did R1 have a plan, and R1 said "yes, I took some pills". V13 said V13 took R1 to the counselor's office to V12 (V12 was sitting in the counselor office with a female staff member). V13 said about 3 minutes later, someone came down the hallway and said R1 passed out. V13 said V13 called 911 and was getting R1 paperwork together, the other nurse was giving R1 medical attention until the paramedics arrived. V13 said V13 saw the medics put R1 on the stretcher. V13 said R1 was lethargic and mumbling when V13 saw R1. On 11/23/21 at 10:26a.m, V2 (Social Service Director) said "If a resident approaches a counselor with feelings of depression, the counselor should immediately stop and talk to resident and give the resident the opportunity to process what is triggering them, making them depressed." V2 said, The role of the counselor is to assess the intensity of the depression, inquire about what's causing the depression, and to get an idea of what's happening with the resident at that moment. The counselor should look at the medical record to see of the resident is being treated for depression and also communicate with medical professional as appropriate." V2 said, "If a resident is having complaints of suicidal ideations, the expectation would be to address the concern in the same manner, ask about a plan, see if the plan can be defused, try engaging with the resident to talk them out. Staff should look at history of suicidal ideations, and continue to engage with resident and contact the psychiatrist."	S9999		

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S9999	Continued From page 11 On 11/24/21 at 1:36p.m, V12 (Psychiatric Rehab Support Counselor) said on 10/14/21, R1 approached V12, stating R1 was feeling depressed. V12 said V12 was conducting the smoke break for the other residents, and V12 took R1 to talk to the nurse, V14. V12 said V12 took R1 to the nurse so the nurse could get R2 "through it". When asked did V12 follow up with the nurse, V12 then said the intent was to take R1 to the nurse so she would know what was going on with R1. When asked what happened when R1 approached you the second time with thoughts of feeling suicidal, V12 said V12 asked another nurse to monitor R1, but V12 does not know who the nurse was. V12 said when V12 finished smoke break, V12went and got R1 from the nurse, and that's when R1 said R1 was suicidal and had taken pills. V12 was asked who the nurse was. V12 initially said, "I don't know", then V12 said the nurse was V14. V12 said V12 doesn't know how much time R1 spent with the nurse when R1 initially had complaints of feeling depressed. V12 said V12 does not know what R1 talked to the nurse about when V12 took R1 to the nurse with complaints of feeling suicidal. V12 said, "Normally if the resident come and mentioned they are feeling depressed, I can stop and talk to them, sit down and have 1:1 space for ventilate and process their feelings"; V12 would inform the nurse , call the psychiatrist as necessary. V12 said, "all I know is when I came back from conducting smoke break, I went to get (R1) from the nurse". V12 reviewed R1 mood assessment on the MDS and said a score of 15 shows moderately severe mood symptoms. On 11/24/21 at 2:04p.m, V14 (Nurse) said V12 brought R1 to V12 once, and it was for monitoring R1 for suicidal ideations, not for feeling	S9999		

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S9999	Continued From page 12	S9999		

depressed. V14 said R1 was in the telephone room (across from the nurse station on C and D wing) and V14 was standing near the nurse station passing medications to the residents. V14 said V14 was able to see R1 from V14's position. V14 said V12 did not bring R1 to V14 for feelings of depression. V14 said V14 did not talk to R1 about anything, not about depression, and not about feeling suicidal. V14 said when V13 (Nurse) came to the unit, she escorted R1 to V12 for being suicidal. V14 said V14 was the only nurse working on the C and D wing initially until V13 arrived.

On 11/24/21 at 3:55p.m, V6 (DON-Director of Nursing) said the nurse should check the residents mouth to ensure they are swallowing their medications during every medication administration.

On 11/19/21 at 1:00p.m, V6 (Director of Nursing, DON) said R1 does not have an order to self-administer medication.

Medical records were requested on 11/19/21 for initial admitting hospital. Medical records have not been received during this investigation.

Facility smoke times schedules shows, in-part, smoke break from 8:00a.m to 8:40a.m.

Facility policy Titled "Storage of medications",effective date 10/25/2014, shows, in-part, the policy, "Medications and biologicals are stored safely, securely, and properly, following manufactures recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy, personnel, or staff members lawfully authorized to administer medications."

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 12/03/2021

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

(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 13 Facility policy Titled "Medication Self-Administration",effective date 10/25/2014, shows, in-part, policy, "In order to maintain the resident's high level of independence, resident who desire to self-administer medication are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other resident of the facility and there is a prescribers order to self-administer." Facility Policy Titled "Contraband Materials, Inspection of rooms, safe storage and use of recording Devices", with most recent date of 1/07/2020, shows, in-part, Introduction: "This organization reserves the right to conduct inspections if there is reason to suspect/believe that a resident has contraband items/ materials in his/her possession. These items include but are not limited to alcohol, illicit (street or over the counter) drugs, weapons (including any sharp objects/ ammunition) and smoking materials (if the individual has assessed as dangerous and irresponsible with smoking related items). The individual may also be appropriately checked to look for suspected lost or stolen property, if reasonable suspicion exits. No over the counter medication may be kept by the resident. These items must be turned over to facility personnel immediately upon arrival. The origination will try balance individual rights against the safety needs of peers, visitors and staff members in making decisions about further investigation of contraband. In situations where illegal activity appears to have taken place appropriate authorities will be notified. Again, safety and security are of the utmost concern. Policy; the following items are not allowed in resident's rooms at any time and are not allowed on the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 14 resident's person unless permission has been granted from administration and supervision is being provided: lighters matches, cigarettes, drugs, over the counter medication, drug paraphernalia, glass bottles, toaster oven, hot plates, coffee makers, rice cookers, microwave oven, silverware, knives, fire arms and ammunition of any type, alcohol, razors, razor blades, caffeinated beverages, needles, safety pins, housekeeping, laundry supplies, staplers, staples, candles, incense." (A)	S9999		