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 05/11/2023

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 2393769/IL159542	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.3240 a) 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 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.	S9999	Attachment A Statement of Licensure Violations	

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Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to follow its abuse prevention policy and to prevent incidents of staff to resident verbal and physical abuse. This failure affected two residents (R1 and R7) reviewed for abuse. V4 yelled, pulled R1's hair, and hit R1's arms, and V4 grabbed R7 by the left wrist resulting in bruising.

Findings include:

R1's BIMS (brief interview of mental status) score, dated 4/17/23, notes R1's score is 13 out of 15. R1 is able to make needs known.

R1's behavior assessment summary, dated 4/17/23, notes R1 does not exhibit any behaviors.

R1's quarterly assessment, dated 4/17/23, by V11, PRSC (Psychiatric Rehabilitation Services Coordinator), noted R1 is an active speaker that communicates her concerns and desires when the need arises. For the most part, R1 gets along well with staff and her peers. R1 demonstrated she is alert and oriented as evidenced by a score of 13out of 15 on the BIMS, and a mood score of 11 out of 27, indicating moderate depression. R1 has a medical and psychiatric diagnosis that impacts mood and stability. 1:1 psychosocial programming addresses R1's need for increasing

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S9999	Continued From page 2 life management skills, symptom awareness, behavior management to maintain compliance and stability, and also improving communication skills. R1's behaviors care plan, initiated 2/27/2023, notes R1 likes having people pay attention to her. This includes spending time in the hallway, even when there may not be anyone else there. When what R1 says does not get immediate attention, R1 tries harder to get attention by yelling, crying, or cursing demanding to be heard and taken more seriously. R1's psychosocial well-being care plan, initiated 1/27/2022, notes R1 may be at risk for abuse related to attention seeking behaviors, interfering in peers' affairs, anxiety, agitation, or restlessness. R1's mood state care plan, initiated 2/16/2021, notes R1 exhibits signs/symptoms of mood distress related to diagnosis. R1's mood score is 11 out of 27, indicating severe moderate depression. R1 expresses feeling down, depressed, or hopeless and trouble falling or staying asleep most days of the week. R7's BIMS score, dated 4/4/23, notes R7's score is 14 out of 15. R7 is able to make needs known. R7's annual assessment, dated 4/4/23, by V11, PRSC, noted V11 met with R7 to conduct an annual assessment and discuss the goals of her care plan. R7 is alert and oriented to places, persons, and time. R7 was diagnosed with unspecified schizoaffective disorder, a single episode of major depressive disorder, alcohol abuse with alcohol abuse hallucinations, and other medical conditions. At the interview	S9999		

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session, R7 presented with a receptive affect and congruent mood. R7's speech is clear and her hearing appears to be with in normal range. R7's thought process is goal oriented and logical. R7's mood score is 13 out of 27 indicating moderate depression. R7 is encouraged to ventilate feelings with staff whenever R7 is experiencing an increase in agitation or sadness. R7 has a history of becoming verbally aggressive when she experiences increased agitation when provoked. R7 has not expressed aggressive behavior during the last review.

R7's behaviors care plan, initiated 1/3/23, notes R7 exhibits signs/symptoms of depression. Before admission, R7 experienced hallucinations. R7's mood score is 10 out of 27, indicating moderate depression.

R7's psychosocial well-being care plan, initiated 1/3/2023, notes R7 may be at risk for abuse related to diagnosis of schizoaffective disorder.

On 5/8/23 at 10:00am, R1 stated R1 wanted to take a bubble bath on 4/23/23. R1 stated R1 went to the nurses' station to get towels. R1 stated V4, RN (Registered Nurse), instructed R1 to go back to R1's room. R1 stated V4 was yelling at R1. R1 stated V4 came from behind the nurses' station and stood behind R1's wheelchair. R1 stated V4 pulled R1's hairm and hit R1 in the arms before staff came and took R1 to R1's room.

On 5/9/23 at 3:30pm, R1 was re-interviewed regarding the incident. R1's story remained unchanged from previous day.

On 5/9/23 at 1:45pm, R7 stated staff is mean to R7. R7 stated three weeks ago, R7 threw her

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medications on the floor because R7 did not want to take them. R7 stated V4, RN, grabbed R7's left wrist, causing R7 to sustain bruising to that area. R7 stated R7 did not report this incident to any staff.

On 5/10/23 at 10:00am, R2 stated R1 will leave R1's room 3-4 times, starting about 10:00pm sometimes. R2 stated R2 can hear V4, RN, yelling at R1 to get back in R1's room, and V4 is "tired of (R1)." R2 stated the facility makes residents sign a form that residents can be restrained if out of control. R2 stated the restraint is an injection that will make you sleep all day or night. R2 stated R1 was given an injection, and R1 went to sleep.

On 5/8/23 at 6:30am, V4, RN, stated on 4/23/23, R1 returned to facility early from being out on pass with family. V4 stated R1 was supposed to be out on pass with R1's family for a couple of days. V4 stated R1's family informed her that they could not control R1 at home, and brought R1 back to the facility. V4 stated R1 was in wheelchair at nurses' station between 9:30pm and 10:00pm, requesting a can opener to open can of soup. V4 stated she informed R1 they didn't have a can opener; R1 became agitated. V4 stated she attempted to move R1's wheelchair, R1 pushed her wheelchair backwards and locked the brakes on it. V4 stated R1 hit her in left leg with the wheelchair when R1 pushed wheelchair backwards. V4 stated she leaned over the right side of wheelchair to unlock brake. V4 stated R1 was positioned at the front of the nurses' station with wheelchair facing C wing, she was standing behind wheelchair facing C wing with back to main lobby. V4 stated V8, CNA, was sitting in nurses' station at the time of this incident, and came to assist V4. V4 stated there

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were no other residents in hallway at the time of the incident.

On 5/8/23 at 9:10am, V5, DON (Director of Nursing) stated when R1 goes out on pass with R1's family, R1 will exhibit behaviors upon returning because R1 wants to stay at home with family. V5 stated R1 was supposed to be with family for 3 days; family brought R1 back on day 2 due to R1's behaviors at home. V5 stated R1's family was unable to control R1 at home.

On 5/8/23 at 10:00am, R1 was sitting in her wheelchair with her hair neatly pulled back in a ponytail. When questioned, R1 was observed to be fearful to discuss incident that occurred on 4/23/23. R1 was observed to frequently remove her hairband and comb her hair with fingers and then reapply hairband.

On 5/9/23 at 1:45pm, R7 was observed lying in bed in R7's room with covers pulled over cheeks. When questioned, R7 was observed to be fearful to discuss incident and the staff involved.

Review of R1's medical record notes on 4/22/23, R1 is going home for overnight pass today 04/22/23 at 10:00am will be back tomorrow 04/23/2023 by 5:00pm.

On 5/8/23 at 9:20am, V6, ASSD (Assistant Social Services Director) stated V6 was present in the facility until 8:00pm on 4/23/23. V6 stated the incident occurred after V6 left the facility. V6 stated R1 was fine and not exhibiting any behaviors.

On 5/8/23 at 10:00am, V9, CNA (Certified Nurse Aide) stated V9 was in the front lobby at time of incident. V9 stated V9 heard R1 and V4, RN,

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yelling at each other. V9 stated R1 was self-propelling in wheelchair in hallway prior to the incident. V9 stated R1's hair looked tousled after the incident. V9 stated R1 cares about her appearance and fixes her hair frequently throughout the day, about every 2 hours. V9 stated her hair appeared to have been pulled. V9 stated V9 brought R1 back to R1's room and fixed R1's hair.

On 5/8/23 at 10:30am, V8, CNA, stated R1 was coming down the hall, complaining she wanted towels to take a bubble bath. V8 stated R1 was informed R1 would have to wait a minute because there were no towels available at that time. V8 stated then R1 wanted a can of soup opened. V8 stated R1 became upset and started yelling when R1 was informed the kitchen was closed, and V8 could not get a can opener for R1. V8 stated she was at nurses' station charting with her back to R1. V8 stated V4, RN, asked R1 to leave the nurses' station and go to R1's room. V8 stated when V8 turned around, V8 observed V4's hands on R1's wheelchair armrest, and V4 was attempting to re-direct R1. V8 stated when V4 touched her wheelchair, R1 became more upset. V8 stated 2 staff members came and escorted R1 back to her room. V8 stated R1's hair was not tousled prior to the incident.

On 5/8/23 at 10:50am, V7 (security) stated on the evening shift on 4/23/23, she was working at the front desk. V7 stated V13, LPN (Licensed Practical Nurse), was standing at the double doors separating main lobby from nursing units. V7 stated V13 was holding the door open while speaking with V7. V7 stated there was music playing, and V7 observed R1 self-propel past the double doors. V7 stated V7 heard V4 and R1 yelling. V7 stated V7 could hear V4, RN, stating,

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"If I count to 5 and have to get up", then she heard V4 counting. V7 stated when V7 heard V4 say '5', V7 got up immediately and ran towards C-D nurses' station. V7 stated she observed V4 with her hand wrapped in R1's hair, R1 was screaming and crying. V7 stated she yelled out R1's name. V7 stated V4 turned around, and saw V7 coming down the hallway to assist R1. V7 stated V8, CNA, was standing at nurses' station with hands in her pockets, not providing assistance during incident. V7 stated R1 had a clip in her hair, and V7 observed the clip dented/broken in R1's hair. V7 stated V9, CNA, was also in the front lobby at the time of incident, and followed V7 to the C-D wing. V7 stated V9, CNA, took R1 to R1's room to fix R1's hair. V7 stated V7 reported this incident to V3 (Assistant Administrator) immediately.

On 5/9/23 at 12:20pm, V10, PRSC (Psychiatric Rehabilitation Services Coordinator), stated R1 exhibits behavior such as attention seeking. V10 stated sometimes R1 just wants to talk to someone. V10 stated R1 goes out on pass with R1's family for overnight visits. V10 denied R1 going on longer visits with family. V10 stated R1 goes with R1's family on Saturdays at 10:00am, and returns the following day between 4:00pm and 5:00pm. V10 stated R1 usually gets upset when R1 returns because R1 wants to stay at home with family.

On 5/9/23 at 12:40pm, V11 PRSC stated that R1 reported incident to him on 4/24/23. V11 stated that R1 was trying to get some of R1's clothes to laundry and V4 RN was trying to prevent R1 from doing that due to time of day. V11 stated that R1 informed him that V4 stood up came to R1 trying to make sure R1 went to her room. V11 stated that R1 showed V11 some redness on R1's right

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arm that resulted from the incident the previous evening. V11 stated that R1 informed him that V4 grabbed the back of R1's neck and hit her arms.

On 5/9/23 at 12:50pm, V12, CNA, stated R1 informed V12 on 4/24/23 that R1 had an incident the night before. V12 stated R1 mentioned R1 was scolded and yelled at. V12 stated R1 would not tell V12 the name of the staff member involved or any further details of the incident.

On 5/9/23 at 1:20pm, V13, LPN, stated V13 is not sure exactly what happened on 4/23/23 between V4 and R1. V13 stated V13 was on a break at the time of the incident. V13 stated V13 did a wellness check on R1; R1 would not tell V13 what happened. V13 stated R1 looked upset. V13 stated R1 does get agitated on Sundays after being with R1's family because R1 does not want to come back. V13 stated R1 returned to facility at 4:30pm on 4/23/23. V13 stated R1 was calm and cooperative by 7:00pm.

On 4/23, V13, LPN, noted: (recorded as late entry on 04/24/2023 10:24pm). V13 was away from the unit and when V13 returned, V13 was made aware of an allegation of abuse between R1 and V4. V13 immediately went to R1's room to assess R1. R1 was in room sitting in wheelchair. R1 was calm and safety was maintained.

Review of this facility's investigation into an allegation of abuse involving R1 and V4 notes this event occurred on 4/23/23 at 10:00pm.

Review of V4's timecard, dated 4/23/23, notes V4 did not clock out and exit this facility until 11:45pm.

Review of this facility's abuse prevention policy,

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S9999	Continued From page 9 dated 02/2017, notes this facility affirms the right of its residents to be free from abuse. This will be done by immediately protecting residents involved in identified reports of possible abuse and implementing systems to promptly and aggressively investigate all reports and allegations of abuse. Verbal abuse includes, but is not limited to, threats of harm, saying things to frighten a resident. (B)	S9999		