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 09/10/2022

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 August 19, 2022 IL150601	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1210 b) 300.1210 c) 300.1220 b)3) 300.3210 t) 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These requirements were not met as evidenced by: Based on observation, interview, and record review, the facility failed to keep residents free from physical abuse from another resident, failed to provide residents with supervision while in the	S9999		

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dining room at breakfast time, and failed to monitor residents while in the smoking area. These failures applied to four of four residents (R1, R2, R3, and R4) reviewed for abuse and supervision, and resulted in R2 getting hit in the face and sustaining an injury to the right eye, and R3 being transferred to local hospital for evaluation after being hit in the face.

Findings include:

1. R1 is a 68-year-old male who was originally admitted to the facility 7/8/2005, with diagnoses including: bipolar disorder, major depressive disorder, schizophrenia, and schizoaffective disorder.

During his stay at the facility, R1 has been assessed to have aggressive behaviors toward staff and residents.

Care plan for R1, dated 08/16/2022, indicated R1 has a history of aggressive behavior, as he may experience an increase in agitation related to delusional thoughts.

R2 is a 61-year-old female, originally admitted to the facility for 4/18/16, with diagnoses including Bipolar disorder and chronic obstructive pulmonary disease.

R2 does not have a history of being physically aggressive per EMR (electronic medical record) documentation.

Review of facility records documents on 7/19/2022 at approximately 7:00 AM, R1 and R2 were in the dining room preparing for breakfast. R2 was speaking with another resident at the table, when R1 approached her, and initiated a

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verbal altercation. The verbal altercation escalated when R1 picked up a chair and used it to hit R2 across the face. R2 sustained a scratch under her right eye that resulted in bleeding, swelling, and bruising. There was no staff present who witnessed this altercation or intervened at any time.

R1 was sent for a psychiatric evaluation, and R2 refused to seek medical treatment outside of the facility.

R1 was readmitted to the facility 8/31/22, with newly initiated care plans addressing aggressive behaviors. No care plans for behaviors prior to this incident were given, despite R1 having a history of aggression.

On 9/9/22 at 1:30PM, R2 was observed in room, ambulating with walker, alert and oriented. A dark colored bruise was noted under the right eye. R2 said, "(R1) took a chair and hit me in the head. I didn't do anything to provoke him, he said I was talking too much crap. Some people (residents) saw it, but some didn't. We were waiting for breakfast, and I was talking to my friend. (R1) came over and got mad and threw a chair on my head. The whole eye was bleeding, and I was so angry I wanted to throw a chair at him too. I went to the nurse and I told them I didn't want to go to the hospital; they sent him instead. There was no staff to break us up. After he hit me I went to the nurse."

On 9/09/22 at 2:25 PM, V5, Clinical Director, said, "(R1) displays behaviors of agitation sometimes. I believe at the time of this incident, staff were on their way to the dining room, and the altercation was unwitnessed."

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On 9/09/22 at 2:38PM, V1, Administrator, said, "Staff should be always supervising the dining room when it is open. If we only have one staff available to monitor, all the residents are moved to one side."

On 9/09/22 at 2:57PM, V6, Certified Nursing Assistant/CNA, said, "I was in the small dining room, either picking up trays, passing trays, or supervising. I remember (R2) yelling and cursing. I didn't witness a physical altercation. I didn't go to see what was going on because I thought someone else was on that side of the dining room."

EMRs reviewed for R1 and R2. Both R1 and R2 were assessed for being at risk for sustaining abuse.

2. R3 is a 68 year old male, originally admitted to the facility 11/30/2009, with diagnoses including hemiplegia and hemiparesis following cerebral vascular disease affecting left non-dominant side, dementia, and schizoaffective disorder.

Facility Abuse Risk Review (dated 5/16/22) stated R3 is is at-risk for all kinds of abuse related to severity of mental illness symptoms, cognitive functioning, and medical co-morbidity. No interventions were indicated.

R3 is alert and oriented, and able to follow simple commands upon request.

On 9/9/22 at 1:59PM, R3 was observed in bed, alert, dressed, and unable to answer questions appropriately.
At 2:05 PM, V3, Licensed Practical Nurse/LPN said, "I am the nurse for (R3). He might not be able to reply, but he uses gestures in order to

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S9999	Continued From page 5 express himself. That could make him more vulnerable to abuse." R4 is a 66 year old male, who was admitted to the facility 8/10/18, with diagnoses including schizophrenia. R4 was originally admitted to the facility from a local hospital, where he was primarily treated for aggressive behaviors. During his stay at the facility, R4 was identified as a criminal offender with a history of violent behavior, and exhibited aggressive behaviors towards staff and residents. Facility records show on 7/01/22, R4 approached R3 in the smoking area, and physically attacked him. R3 sustained knots on his head and was hospitalized for further evaluation. A staff member on duty at the time, indicated R3 and R4 were not in their field of view when this incident occurred ,because they were in the doorway of the smoking area with another staff member, who was also responsible for monitoring. R4 was sent to the hospital for psychiatric evaluation and did not return. On 9/9/22 at 4:14PM, V7, CNA, said, "During smoke time, (R4) came outside, started yelling and hitting on (R3). Me and the Activity Aide were at the door passing out the cigarettes. (R3) can't do much; he's not very strong, so he was just sitting there getting hit. (R3) was sitting by the gate, not right in front of the door where he could be easily seen. Me and the Activity Aide broke it up after (R4) hit (R3) in the face. This incident could have been prevented if someone was outside and keeping a closer eye on the patio. On 9/10/22 at 1:38 PM, V8, Activity Aide, was observed during smoking activity. V8 said, "I am	S9999		

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S9999	Continued From page 6 the only person out here physically at the moment, but there should be three staff members assigned to monitor the smoking area when its open. This does not include the person at the door who passes out the cigarettes. The staff who are monitoring are supervising to make sure that the smoking rules are being enforced and to prevent altercations. Whenever residents are in a room together, they need to be supervised." On 9/10/22 at 2:38PM, V1, Administrator, said, "There should be three people monitoring the smoking area at all times." Facility Abuse Policy reviewed which states in part; Supervisors will monitor the ability of the staff to meet the needs of residents, including that assigned staff have knowledge of individual resident care needs. Situations such as inappropriate language, insensitive handling, or impersonal care will be corrected as they occur. Facility was asked for any policy related to supervision during dining or smoking upon; none were provided during the course of this survey. (B)	S9999		