

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000437		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/03/2025	
NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST GRANT STREET , MACOMB, Illinois, 61455			
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S0000	Initial Comments Complaint Investigations 2527310/2582424 2526144/1070414		S0000			09/04/2025	
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210a) 300.1210b) 300.1210d)1)2)3) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in		S9999			09/04/2025	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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. 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. 2) All treatments and procedures shall be administered as ordered by the physician. 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. These requirements were not met as evidenced by: Based on interview and record review the Facility failed to monitor and treat acute medical conditions for two of seven Residents (R4 and R9) reviewed for quality of care in a sample of nine. This failure resulted in R4 and R9 requiring hospitalization. Findings include: The Facility Physician Orders Policy, revised 2/14/23, documents: to provide guidance to ensure physician orders are transcribed and implemented in accordance with the professional standards. The Facility Acute Respiratory Illness Policy, initiated 1/31/25, documents: the Facility follows			S9999			

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S9999	Continued from page 2 current guidelines and recommendations for managing acute respiratory illness; and is defined by two of the following signs and symptoms (shortness of breath/difficulty breathing, which may manifest as increased fatigue and low oxygen saturation in the blood (normal levels are between 95 percent and 100 percent, but may vary for people with certain medical conditions). The Facility Registered Nurse Job Description, undated, documents: ability to work independently or part of a group; direct day-to-day functions of the nursing assistants in accordance with current rules, regulations and guidelines that govern long-term care; ensure that all nursing personnel assigned to you comply with the written policies and procedures established by the Facility; responsible for complying with Facility policies and procedures; cooperate with other Resident services when coordinating nursing services to ensure that Resident's total regimen of care is maintained; participate in the development, maintenance and implementation of the Facility's Quality Assurance Program; perform all tasks in accordance with established policies and procedures and as instructed by supervisor; sign and date all entries made in the Resident medical record; charts nurses' notes in an informative, relevant, concise and descriptive manner that reflects the care provided to the Resident, as well as Resident's response to the care; provides direct Resident care; review the Resident chart for specific treatment and medication orders as necessary; implement and maintain established nursing objectives and standards; educates the Resident through use of nursing knowledge and skills according to their needs and promote their mental and physical well-being; responsible for interpretation and execution of Physician orders and calling Physician as indicated; make periodic rounds to observe and evaluate Resident's physical and emotional status and to ensure the continuing quality Resident care; assess the total needs of the Residents and adjust care plans as needed; reviews care plan daily to ensure that appropriate care is being rendered; responsible for accurate observation, evaluation and reporting of Residents symptoms and change of condition reactions and progress to the Physician and shift supervisor; assures Resident care delivery is in accordance with the Facility policies and procedures; notifies Resident's attending Physician and family when the Resident is involved in an occurrence or change in condition; responsible for administering and documenting medications according to the Physician order and plan of care; responsible for competent administration of care and treatments according to the Physician orders and Facility policy		S9999				

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S9999	Continued from page 3 and procedure at a minimum; responsible for administration and control of narcotics and controlled drugs according to state and federal regulations, Facility policies and procedures; ensure that Residents who are unable to call for help are checked frequently; make periodic checks to ensure that prescribed treatments are being properly administered by nursing assistants; Resident Rights in regards to psychosocial needs and caring for aged, ill, disabled and cognitively impaired, Communication/Personal skills and Medication rights; ensure that all Residents are treated fairly and with kindness, dignity and respect; knowledgeable to all Residents' Rights according to Facility policy and Regulations; and ensure that call lights are answered by all employees of the Facility, regardless of the department. The Facility Resident Council Notes, dated 7/2023, document Nursing Department issues with Residents stating, "a male nurse on night shift (V8/Agency Registered Nurse/RN) is still missing wound treatments" and that V8 (RN) told the Resident Council member that "it is the day nurse's job to do the wound treatment, not his." Residents also have concerns that V8 (RN) "skips their medication pass (med pass) every time he works." The Facility Concern/Grievance Form, dated 7/2025, documents a concern with "male nurse on night shift (V8/RN-Registered Nurse)." The review and action taken documents that the Facility quit using (employing) V8 (Agency RN). 1.R9's Physician Order Sheet/POS, dated 8/30/25, documents R9's diagnoses including Generalized Anxiety, Hypertension, Congestive Heart Failure, Obesity, Mitral Valve Stenosis, Repeated Falls, Cardiomyopathy, Recurrent Moderate Chronic Obstructive Pulmonary Disease/COPD, Emphysema, Anemia, Cerebral Infarction, Chronic Kidney Disease Stage Three and Chronic Respiratory Failure with Hypercapnia. R9's POS, dated 8/30/25, also documents Physician Orders for a breathing machine (Bi-pap), keep head of bed elevated at 30 degrees as needed for shortness of breath, Oxygen therapy at four liters per nasal cannula, Nebulizer treatment (Proventil, Ipratropium and Albuterol) and medications (Apixaban, Spironolactone and Bumetanide for Congestive Heart Failure and Wellbutrin for Depression). R9's current Care Plan documents: to observe for presence of respiratory infection symptoms and shortness of breath that is unrelieved and report to			S9999			

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S9999	Continued from page 4 Physician; Advance Directive status of Full Code; has alteration to ability to care for self and to report any declines to Physician; alteration to Respiratory System due to Chronic Respiratory failure and to monitor vital signs; administer medications and treatments ordered by Physician and monitor for side effects and effectiveness of current medication regimen; assess and monitor respirations and breath sounds noting rate and sounds; assist me to assume a position of comfort, educate me on breathing techniques; monitor for change in condition and notify the Physician; monitor for signs and symptoms of asthma attack; and monitor vital signs that they are in acceptable range. R9's Nursing Note, dated 7/3/25 at 6:24 am, documents an entry by V3 (Licensed Practical Nurse/LPN) stating "when getting report from the night shift nurse (V8/RN), it was reported that (R9) was having trouble breathing and (R9's) pulse oximeter (SPO2) as at 78 percent. (V8) stated that (V8) gave (R9) two breathing treatments and now (R9) is in the 80's. (V3) went to assess (R9) and found (R9) lying in bed with a breathing treatment on and pulse ox/oxygen level at 82 percent and (R9) was mouth breathing and stomach breathing. (R9) was pale and clammy and complained of left arm pain." (V3/LPN) called Emergency Services/EMT and (R9) was transported to the local hospital Emergency Department for evaluation and treatment. The Nurses Note also document "when EMTs arrived, they put (R9) on ten liters of oxygen on a re-breather bag" and (R9's) oxygen saturation level increased to 92 percent. R9's Nursing Notes do not document entries from V8/RN for vital signs, breathing difficulties or nebulizer treatments. R9's Nursing Note, dated 7/3/25 at 9:56 am, documents R9 is admitted to Hospital Intensive Care Unit for fluid overload, exacerbation of COPD and Pneumonia. R9's Medication Administration Record, dated 7/3/25, does not document R9's respiratory status, medication therapy or administration of nebulizer treatments. R9's Hospital Summary, dated 7/6/25 through 7/16/25, document that R9 was admitted to the local Hospital on 7/3/25 and transported to a larger hospital for diagnoses including Respiratory Distress, Pneumonia, COPD exacerbation, Congestive Heart Failure, Atrial Fibrillation, Acute Kidney Injury and Respiratory Failure with Hypoxia. R9 was admitted to the Intensive Care Unit, sedated and intubated with an endotracheal tube. The Hospital notes also document that R9 was placed on a feeding tube.		S9999				

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S9999	Continued from page 5 2.R4's Physician Order Summary Report/POS, dated 9/2/25, documents diagnoses including Schizophrenia, Bipolar Disorder, Hypertension, Borderline Personality Disorder, Depression, Insomnia, Generalized Anxiety Disorder, Congestive Heart Failure, Panic Disorder and Episodic Paroxysmal Anxiety. The POS also documents an order for the monitoring of Anti-Anxiety, Anti-Psychotic, Sedative/Hypnotic and Anti-Depression Medication. R4's Medication Administration Record, dated 7/8/25, documents V8's (RN) signature for administration of Depression medication (Fluvoxamine), Schizophrenia medication (Olanzapine) and Anxiety medication (Hydroxyzine Hydrochloride and Clonazepam) for the scheduled administration time of 6:00 am. R4's Medication Administration Audit Report, dated 8/30/25, documents that on 7/8/25, V8 (Registered Nurse/RN) signed out (administered) Depression medication (Fluvoxamine), Schizophrenia medication (Olanzapine) and Anxiety medication (Hydroxyzine Hydrochloride and Clonazepam). R4's current Care Plan documents: Advance Director of Full Code; dependent on staff for meeting emotional and physical needs and staff to converse while providing care; has self-care deficits and need assistance to complete quality of care and has shortness of breath with panic attacks, anxiety, educate on self-care needs; impaired physical mobility related to Congestive Heart Failure, COPD and increased weakness; check for breath sounds and monitor/document labored breathing; administer medications as ordered and monitor/document for side effects and effectiveness; maintain consistent routine to insure compliance and avoid confusion; uses anti-anxiety medication and monitor every shift for safety; unexpected side effects of medication (Hydroxyzine and Clonazepam) are mania, hostility, rage, aggressive or impulsive behavior and monitor/record occurrence document per protocol; uses anti-psychotic medications (Olanzapine) and administer as ordered by Physician and monitor/report adverse reactions and behavior symptoms; uses anti-depressant medication (Fluvoxamine) and administer per Physician order and monitor/document and report adverse and behavior symptom; and has chronic arthritis pain and monitor and observe for changes in usual routine. R4's Nursing Note, dated 7/8/25 at 6:19 am, documents an entry by V13 (Registered Nurse/RN) stating "met in full blown anxiety, jittery, exasperated and sweating profusely at resumption (5:55 am). On checking the		S9999				

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S9999	Continued from page 6 (electronic medical record), all 5:00 am medications were given, though (R4) kept asking for (R4's) medications that (R4) has not gotten them." The Nursing Note also documents "it has been numerously stated by most Residents that the nurse in question (V8/Agency Registered Nurse/RN) rarely give them medications nor attends to needs by request if (V8's) assigned Certified Nursing Assistants ask him." R4's Nursing Note, dated 7/8/25 at 6:49 am, documents that R4 continues to be anxious and that no anti-anxiety medications can be given or are scheduled. Emergency Services was called and R4 was transported to the local hospital for evaluation. R4's Nursing Note, dated 7/8/25 at 2:38 pm, documents that R4 returned from the local hospital Emergency Department. R4's local hospital Emergency Department notes, dated 7/8/25, documents R4 is having "shakiness, rapid breathing and wheezing. Per Emergency Medical Services, the Nursing Home (Facility) staff reported that usually once (R4) receives his medications all these symptoms resolve. The Medication Administration Record shows that (R4's) medications were given at 5:11 am but (R4) states that (R4) did not receive his medications." On 8/29/25 at 11:52 am, R7 stated, "I did not always get my medication when (V8) worked." On 8/29/25 at 11:30 am, R4 stated, "I did go the hospital when I did not get my medicine that morning. I get anxious and I need to get my medicine." On 8/29/25 at 2:13 pm, V22 (Insurance Representative) stated, "I have to go to the Facility and check on my Residents and when I arrived that morning on 7/8/25, (R4) was sweating through (R4's) clothes and having a really hard time breathing. (R4) kept saying that (R4) did not get (R4's) medications. (R4) deserves more credit, even though (R4) has issues, but I truly believe that (R4) did not get the 6:00 am medications and (R4's) anxiety got out of control. They even sent him to the hospital because of it." On 8/31/25 at 6:55 am, V9 (Certified Nursing Assistant/CNA) stated, "I would rarely see (V8/RN) down the hallways passing medications. I know that some nurses are faster than others, but if I did see (V8) passing medications, (V8) got done way quicker than the other nurses. I went to (V19/Former Director of Nursing) and (V5/Assistant Director of Nursing) multiple times complaining about (V8) not doing (V8's)			S9999			

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S9999	Continued from page 7 job and nothing ever came of it. I was furious having to work with (V8/RN) and I told (V19) and (V5) that I will not work with (V8) anymore if (V8) was in the building. Also, (V8) would leave the premises and be gone for over an hour and on night shift, the nurse is not allowed to leave the premises in the event of an emergency. I would tell (V8) that a Resident needed help from a nurse or something needed looked at, and (V8) would never follow up. I would work 1:00 am to 1:00 pm, when I worked and on 7/9/25, I came on to my shift, (R9) was having trouble breathing and gasping for air. (R9's) oxygen was down around 78 percent and it should be in the nineties. Even though (R9) had COPD (Chronic Obstructive Pulmonary Disease), I knew that (R9) was in distress. I went to (V8/RN) and told (V8) that (R9's) vital signs and pulse ox (oxygen level) was extremely low and (V8) did not even go look at (R9) and (V8) said 'she has COPD, she is going to have trouble breathing' and just shook it off. I even called one of the bosses (V19 and V5) but I could not get ahold of them because they were probably sleeping. At the end of our shift, around 6:00 am, I think he finally went down and gave (R9) a breathing treatment, but by the time the day shift nurse came on, they sent (R9) out immediately to the hospital and (R9) was admitted to the Intensive Care Unit at the hospital. My co-workers and I were furious, we heard (V8/RN) giving report to the day shift nurse and (V8) told them in report that (R9) had just started acting like this and I spoke up and told them that (V8) was lying because (R9) had been like that since I came on shift at 1:00 am. I would tell (V8) that someone would need a pain pill or that they needed something and (V8) would never follow up. All (V8) would do, was sit on (V8's) (electronic device) and watch movies." On 8/31/25 at 8:19 am, V24 (Certified Nursing Assistant/CNA) stated, "I worked with (V8/RN) a lot on night shift and I would never see (V8/RN) doing a full medication pass or taking the medication cart down the hallways passing medications. When I work with other nurses, they always take the medication cart down the hallways. That 6:00 am medication pass usually takes the night shift nurse quite a long time to complete it, and I would never see (V8/RN) doing that medication pass. When (V8/RN) worked, I always had Residents tell me that they did not get their treatments or medication, (R1, R8, R11 and R12) were just the ones off of the top of my head that I can remember. Basically, (V8/RN) would sit at the nurse's desk and watch movies all night. The CNA's would go to him when a Resident needed something from him and (V8/RN) would never check on the Residents. I even asked (V8/RN) how (V8) got (V8's) stuff done and was always able to sit		S9999				

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S9999	Continued from page 8 at the nurse's station and (V8) told me that (V8) pulls all of the medications at the beginning of (V8's) shift. I never even seen him do that or spend that much time at the medication cart. I know that a lot of us complained to management about (V8), but (V8) just kept coming back to work and nothing was done, until I think they fired him." On 8/29/25 at 9:40 am, V15 (Activity Assistant) stated "The Resident Council does have specific complaints about several Residents complaining that the night shift male nurse (V8) does not do treatments and does not give medications. They have also complained that (V8) is not recording stuff right in their charts. I even had one Resident complain that (V8) told him that "it is not my job to treat your wounds, it is day shift's job. I think that (V8) did lose (V8's) job here because of all of the complaints." On 8/29/25 at 9:46 am, V16 (Activity Director) stated "I used to be in charge of the Grievances, but they took them away from a few months ago, but now I just got the Grievance Book back two days ago, and I am not sure what happened to my copies of Grievances from before. I am not sure who was doing them (Grievances) until now, but I do remember complaints from Resident's about the male night shift nurse (V8) not recording stuff right and not doing their job. I think they finally got rid of (V8)." On 8/29/25 at 12:43 pm, V3 (Licensed Practical Nurse/LPN) stated, "I was the day shift nurse that relieved (V8/RN) on night shift. I got so sick of coming onto shift and (V8/RN) not taking care of the Residents at night, I was always coming into a mess when I follow (V8). On 7/3/25, I came on shift and immediately found (R9) having a very hard time breathing. In Report (V8) told me that the breathing issues just started and the CNAs came up to me and told me that (R9) had been having breathing issues the entire night shift, and had me go look at (R9) right away. (R9) had a nebulizer mask on and (R9's) oxygen saturation was in the low 80's. I immediately sent (R9) out to the hospital and (R9) was admitted to the intensive care unit. I had reported (V8/RN) multiple times to management (V5/ADON) and (V1/Administrator) and nothing seemed to happen. Every time I followed (V8) I would have multiple Resident's complain about not getting medications or getting taken care of. From what I have heard, and I know it is only hearsay, but (V8) would sit at the Nurse's Station the entire shift and watch movies. I got so sick of Resident's complaining about (V8). Finally, staff were starting to want to call off if (V8) was working. I cannot tell you		S9999				

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S9999	Continued from page 9 how many complaints I got from Residents that their blood sugars were not being checked (R7), treatments were not getting done and I even had a dialysis Resident (R10), tell me that (R10) did not get the right medications on the 6:00 am medication pass when (V8) worked. We did not have a DON (Director of Nursing) for some of that time, our former DON (V19) was no longer here, so no one was really in charge. (V8) was always sitting at the Nurse's Station when I got in to work and from what I hear on the morning of 7/3/25, the CNAs (V9) said the (V8) had been sitting at the Nurse's Station since 3:30 am. I would check the computer after I would get all these complaints from Resident's and (V8) had always signed everything out so it was hard to prove anything, although I could not find that (R9's) nebulizer treatment was signed out. When multiple staff members, get multiple complaints from Residents, over and over again on the same nurse (V8), I feel that it is warranted and needed checked in to. On 8/29/25 at 10:15 am, V13 (RN) stated, "I work First Shift and (V8/RN) worked Third Shift, which means that I started my shift at 6:00 am and took report from (V8/RN). (V8/RN) was temporarily employed here for a few months through an Agency and was not one of our actual employees. On 7/8/25, when I came on to my shift, the CNAs were complaining that (R4) was having increased anxiety, sweating really bad and having trouble breathing. (R4) kept asking for (R4's) medication. I checked the electronic medical administration record and it was documented that (V8/RN) gave (R4's) medications, but (R4) kept asking for the medications and saying that (R4) did not get them. The nighttime staff would tell me that (V8/RN) was not helping (R4) on the Night Shift. (R4) does have psychological diagnoses but (R4) knows better if (R4) gets (R4's) medication or not. I knew that something was wrong with (R4) because he was sweating and having trouble breathing, so I immediately called Emergency Services (911) and sent R4 out for evaluation at the hospital for (R4's) anxiety. I believe that (R4) did not get (R4's) medications that day, even though (V8/RN) signed them out. I have taken care of R4 for over three years, and I know that if (R4) gets (R4's) scheduled medication, that it is effective for (R4). Every time that I followed (V8/RN), multiple Residents would complain that they did not get their medications or treatments from (V8/RN) on night shift. The CNAs would complain to me that (V8/RN) would not take care of the Residents when they had to approach (V8/RN) with a nursing need for a particular Resident. They also complained that (V8/RN) would do nothing but sit at the nursing station and watch movies on (V8's) phone, and		S9999				

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S9999	Continued from page 10 that they never saw (V8) take the medication cart up and down the hallway for the heavy 6:00 am medication pass or passing medications. I think that (V8) was very strategic with certain Resident's depending on their cognition as far as not giving medications. I told V1 (Administrator), V19 (Former Director of Nursing/DON), V5 (Assistant Director of Nursing/ADON) multiple times about (V8) not doing the job, then I would come on shift and have to clean everything up and deal with it. (V8) should have given medications and sent out (R4) and (R9) to the hospital way before us first shift nurses got in. Those poor Residents sat there for hours without (V8) monitoring or helping them." On 8/30/25 at 11:44 am, V8 (Agency Registered Nurse/RN) stated "They came to me about (R9) not breathing well, but (R9) had COPD for gosh sakes, so (R9) was not going to be breathing well. I did give (R9) a nebulizer that morning, but I did not sign it out. (R4) was so confused, did anyone take into consideration that (R4) probably does not remember getting his medications. Honestly, does it really matter on medications if a dose, here or there, does get missed. As far as I am concerned, if I signed it, I gave it." On 9/2/25 at 9:54 am, V4 (Ombudsman) stated, "I heard they had problems with a night shift nurse over there, from the Residents. Something with medications and not sending people out to the hospital." On 8/29/25 at 11:10 am, V5 (Assistant Director of Nursing/ADON) stated, "I did hear the staff and Residents complaining about (V8) not doing his job. We needed our third shifts covered and needed him still to come in. I am not quite sure if (V19/Former DON) was still working here or not, so I am not sure who really took care of the issues. (V8) was in charge of the entire building on night shift, since there was only one nurse on duty. I would hear that he would leave sometimes for lunch and that definitely was not allowed. We ended up terminating (V8) through the Agency due to all of these issues." On 8/29/25 at 10:10 am, V1 (Administrator) stated, "(V8) was employed through an Agency and because we were aware that (V8) was not performing the job duties, so we 'DNR'd/Do Not Rehire. (V8), so basically (V8) was terminated." (B) 2 of 2 300.610a) 300.1210b)		S9999				

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S9999	Continued from page 11 300.1210d)6) 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. 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: 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. These Requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to prevent an injury for one of three residents (R1) reviewed for accidents in a sample of nine. This failure resulted in R1 receiving a large hematoma under both eyes and across the bridge of R1's nose causing R1 pain and requiring R1 be sent to the Emergency Room. Findings include: Resident Rights Handbook documents Your rights to		S9999				

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S9999	Continued from page 12 safety "Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike." The Fall Reduction Policy dated 10/30/24, documents "Purpose: to provide an environment that remains as free of accident hazards as possible. Definition of Fall: A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object, excluding falls resulting from violent blows or other purposeful actions. A near fall is a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips but is able to regain control prior to falling." R1's computerized Medical Record documents that R1 is a 64-year-old female that admitted to the facility on 4/28/23 with diagnoses which included Systemic Lupus Erythematosus, Organ and System Involved Unspecified, Personal History of Transient Ischemic Attack, and Cerebral Infarction without Residual Deficits, Chronic Kidney Disease, Stage 3, Age-Related Osteoporosis without Current Pathological Fracture, Essential (Primary) Hypertension, and Generalized Anxiety Disorder. R1's MDS (Minimum Data Set) assessment dated 5/9/25 documents a BIMS (Brief Interview for Mental Status) of 15, indicating (cognition intact). R1 has no upper or lower extremity impairment, uses no devices for mobility, is independent for activities of daily living, bed mobility, and transfers. R1's Care Plan printed 8/30/25 documents "(R1) currently has an alteration to her Integumentary System d/t (due to) Bruising." Date Initiated: 8/5/2025. On 8/28/25 at 11:20 AM, R1 was sitting in the dining room. R1 had a purplish/green bruising under both eyes and across the bridge of her nose. R1 stated several weeks ago R1 was going to her room on C Hall after supper and tripped over a rug. R1 did not fall to the floor but her head hit a door. R1 did not tell anyone although she did have pain. When R1 got up the next morning a nurse (V13/Registered Nurse/RN) noticed bruising on R1's face. R1 was sent to the hospital to be evaluated. R1 is currently getting Tylenol for pain. R1 also stated "The rug was starting to come up on one end. There have been other people to trip over it (the mat). We (R2/Resident Council President and R1) complained that someone was going to get hurt. They (the facility) removed the rug after I got hurt."		S9999				

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S9999	Continued from page 13 R1's Nursing Note dated 8/5/25 at 6:30 AM, documents "(R1) was ambulating towards nurses' desk, as staff noticed (R1) to have her left eye swollen and black, and continued from her left eyebrow up to her hairline. When staff questioned (R1) as to what had happened, (R1) replied that she had tripped over the corner of the rug that is in front of the back door and the break room door. (R1) stated that (R1) didn't fall, (R1) had caught herself and apparently hit her head on the doorway. (R1) did not report to any staff as she stated she didn't think it was "that bad." Neuro checks initiated. R1's Telehealth Note dated 8/5/25 at 7:00 AM, documents that a nurse reported that R1 experienced a fall last night after tripping over a rug and struck her head. Swelling and bruising were noted around the left eye, extending from the left eyebrow to the hairline. R1 was referred to the emergency room for further evaluation and treatment. R1's Incident Report dated 8/5/25 at 6:30 AM, documents "(R1) was walking by nurses' station and nurses noted (R1) had a black, swollen eye and a bruised area to the top of her left side of head. (R1) stated after supper on 8/4/25 at around 7:30 PM (R1) walked out of the dining room and down the hall, when (R1) walked through the doorway (R1) hit the corner of the rug and tripped over it, (R1) states (R1) tried to catch herself and hit her eye and head on the break room doorway and door frame." Action Taken - R1 was assessed and sent to the Emergency Department for evaluation and treatment. Injury type - left eye. Predisposing Environmental Factors- "Rugs/Carpeting" R1's Emergency Department Notes dated 8/5/25 at 11:23 AM, document History of Present Illness - R1 presents following a fall at (the facility) 16 hours ago. The fall was described as tripped (over floor mat). Location: "Left head (forehead eye (s). The character of symptoms is pain and swelling. The degree at present is 7/10 (Severe pain)." A CT/Computed Tomography of R1's head, cervical spine, and facial bones were done. Findings "A prominent left frontal scalp hematoma hyper attenuating therefore acute measuring about 4 (four) by 1 (one) cm (centimeters). Prominent Soft Tissue Hematoma in the left supraorbital and frontal scalp. Therapy today: over the counter medications including Tylenol and Naproxen. Associated symptoms: headache." Plan – Follow up with primary care physician and continue prescribed Tylenol and Naproxen for pain. R1's Nursing Note dated 8/8/25 at 8:27 AM, documents		S9999				

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S9999	Continued from page 14 "(R1) up for breakfast, bilateral bruising to eyes from previous incident. (R1's) left eye has increased redness." R1's Wound Log printed 8/31/25 documents the following injuries were acquired in the facility. 8/8/25 - left eye 5 cm (centimeter) x (by) 3 cm bruise, right eye 6 cm x 4 cm bruise, bridge of nose 5 cm x 2 cm bruise, forehead 2 cm x 2 cm bruise. 8/15/25- left eye 4 cm x 3 cm bruise, right eye 5.5 cm x 3 cm bruise, bridge of nose 3 cm x 1 cm bruise, forehead 1 cm x 1 cm bruise. 8/22/25 - left eye 3 cm x 2 cm bruise, right eye 4 cm x 3 cm bruise, bridge of nose 3.5 cm x 1.5 cm bruise. 8/29/25- left eye 2.5 cm x 1.5 cm bruise, right eye 3 cm x 2 cm bruise, bridge of nose 3.5 cm x 1.5 cm bruise. Supply Invoice dated 8/4/25 documents that one Loop Edge Mat was ordered. The Fall Tracking Report dated August 2025 documents that R1 fell 8/5/25. On 8/28/25 at 12:22 PM, R2/Resident Council President stated "(R1) tripped on a rug and messed her face up. (R1) looked rough. It was a mat coming from the hall into the TV (television) room. The mat was there to wipe feet on when you come in from outside. There was a section at the end of the rug that was turned up. It was sticking up enough to trip on just on the end. I believe I told (V1/Administrator) about the rug before (R1) fell. Whenever there is a complaint, I take it to (V1) to see what they will do about it." R2 also stated "After (R1) fell they (the facility) took the rug up right away. Why did it take someone to get hurt before they took it up? It (the rug) had been bad for several weeks." On 8/28/28 at 1:40 PM, V3/Licensed Practical Nurse stated that prior to R1's fall, a residents family member (unidentified) came to take a resident out for the day, and the family member tripped on the mat but did not fall. Since it was a weekend V13/Registered Nurse/RN wrote a note and slipped it under the door of the office where Maintenance would see it. V3 also stated "We knew the rug was a problem and reported it. The rug was not removed until (R1) tripped and hit her head. (R1's) accident should have never happened." On 8/28/25 at 1:56 PM, V13/RN stated that on 8/5/25 V13 was sitting at the nurse's desk around 6:30 AM and R1 walked past. V13 saw R1's eye was black. R1 told V13 that she (R1) tripped on the mat in front of the staff breakroom after supper on 8/4/25 and hit her head on		S9999				

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S9999	Continued from page 15 the closed door. It hurt but R1 thought she was OK and did not report the incident. V13 assessed R1, R1 was complaining of pain and there was a bruise under R1's left eye. V13 gave R1 Tylenol and R1 was sent to the Emergency Room for evaluation. At first the bruising was grayish/black under the left eye then it was a dark purple under both eyes. The bruising continued to get worse and was eventually under both of R1's eyes and across R1's nose. V13 also stated "That carpet has been a hazard. It was between seven to nine days before (R1) tripped that a visitor tripped. When the first incident happened, it was a weekend. I wrote a note and put it under the office door for the rug to be fixed or removed. Days later I talked to (V1/Administrator) and said that it (the rug) was a trip hazard. (V1) said he was going to tell corporate and get a new one. (Adhesive tape) was put on the corner of the mat to keep it flat. It lasted a couple of days then it rolled back up again." On 8/28/25 at 4:45 PM V4/Ombudsman stated that she had come into the facility and saw R1's face was bruised under both eyes and across R1's nose. R1 told V4 that she (R1) had tripped over a rug. V4 also stated that she was told by R2/Resident Council President that management was made aware of the rug being a trip hazard before R1 fell. On 8/29/25 at 10:05 AM, V1/Administrator stated that there was a nine foot long by four-foot-wide nonskid mat in front of the entry door. The mat extended past the front of the staff breakroom. The weekend before R1 fell on Tuesday 8/5/25 the residents had complained to V13/Registered Nurse that the rug was in "disrepair and needed replaced." V13 told V1 about the residents' complaints. A new mat was ordered on 8/4/25 but the worn mat was not removed until after R1 tripped and hit her head on the staff breakroom door. After R1's injury on 8/5/25 the rug was removed to prevent any other accidents. On 8/29/25 at 11:36 AM, V14/Maintenance stated that a few days before R1 tripped they (staff) had talked about removing the rug. They were saying "Someone is going to trip over it then (R1) did. "I carried it (the mat) to the dumpster the same day that (R1) fell." (B)			S9999			