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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	**400 WEST GRANT STREET , MACOMB, Illinois, 61455**

(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) COMPLETION DATE
S0000	Initial Comments Second Probationary Licensure Survey	S0000		
S9999	Final Observations Statement Of Licensure Violations 1 of 8 300.610a) 300.1210a) 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 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	S9999		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 1 3-202.2a of the Act) These regulations were not met as evidenced by: Based on interview and record review the facility failed to initiate a Comprehensive Care Plan and interventions for one resident (R5) with Post Traumatic Stress Disorder of five residents reviewed for Comprehensive Care Plans in a sample of 13. Findings include: The facility policy titled “Comprehensive Care Plan”, revised June 25, 2025, documents, “An individualized comprehensive care plan that includes measurable objectives and timetable to meet the resident’s medical, nursing, mental and psychological needs is developed for each resident. 1. Our facility’s care planning/interdisciplinary team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 2. The interdisciplinary team documents in the CAA (Care Area Assessment) summary sheet and/or records in the clinical record: a. The resident’s status in triggered CAA areas. B. The team’s rationale for deciding whether to proceed with care planning; and c. Evidence that the team considered the development of care planning interventions for all RAPs (Resident Assessment Protocols) triggered by the MDS (Minimum Data Set). 3. Each resident’s comprehensive care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident’s strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care; f. Aid in preventing or reducing declines in the resident’s functional status and/or functional levels; and g. Enhance the optimal functioning of the resident by focusing on a rehabilitative program. 4. The resident’s comprehensive care plan is developed within seven (7) days of the completion of the resident’s comprehensive assessment (MDS). 5. Care Plans are revised as changes in the resident’s condition dictate. Care plans are reviewed at least quarterly.” R5's Admission Record documents R5's date of admission to the facility was 12/01/16 and his diagnoses on admission included but are not limited to: Post-Traumatic Stress Disorder Chronic (PTSD), Unspecified Dementia Unspecified Severity with anxiety, Major Depressive Disorder Recurrent, Schizophrenia	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 2 Unspecified, Schizoaffective Disorder Bipolar Type and Personal History of Brain Disorder. R5's Minimum Data Set (MDS) assessment dated 7/2/25, documents R5 has Post-Traumatic Stress Disorder. R5's Electronic Medical Record has no comprehensive care plan or interventions for Post-Traumatic Stress Disorder (PTSD). On 8/20/25 at 11:40am, V15 (Social Service Director/SSD) stated, "I'm going to be completely honest with you, his (R5) care plan does not have anything in it regarding his (R5) PTSD (Post Traumatic Stress Disorder). I have just started updating resident care plans since I know how to now. Prior to the changeover in November I did not put care plans in, I just added things as needed. Since the changeover it's been a learning curve, and I am still trying to figure out how to do somethings that I am now responsible for with the new company." (C) 2 of 8 300.610a) 300.2030 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 300.2030 Hygiene of Dietary Staff Food service personnel shall be in good health, shall practice hygienic food handling techniques, and good personal grooming. This requirement was not met as evidenced by: Based on observation, interview and record review the	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 3 facility failed to cover hair while around food being prepared. This failure has the potential to affect all 48 residents who reside in the facility. Findings Include: The Facility's "Personnel Adherence to Sanitary Procedures" policy dated 11/5/2019, documents, "Food services personnel shall follow appropriate sanitary procedures." "Hair nets or approved hats, covering all of the hair, must be worn at all times while on duty." On 8/19/2025 at 9:45 AM, V4 (Dietary Manager) was standing in the kitchen within arm's reach of V5 (Cook) who was cutting up a big piece of meat. V4 was not wearing a hair net. V4 stated "I usually wear a hair net when I am actually around food or out in the kitchen doing things." The Facility's "Resident Roster" dated 8/19/2025 documents 48 residents currently reside in the facility. (AW) 3 of 8 300.2210b)2) Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. This requirement was not met as evidenced by: Based on observation and interview the facility failed to have a functioning garbage disposal/drain in the dirty dishes area in the kitchen. This failure has the potential to affect all 48 residents who reside in the facility. Findings Include: On 8/19/2025 at 9:30 AM, the dirty dish area that is less than five feet away from the serving window in the kitchen had a sink with standing water with pieces of food floating in it. The water was dark brown.	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 4 On 08/19/2025 at 9:45 AM, V4 (Dietary Manager) acknowledged the sink, “Yeah, our garbage disposal isn’t big enough or something, it does that all the time. It (the water) will go down eventually.” The Facility’s “Resident Census Report” dated 8/19/25 documents 48 residents currently reside in the facility. (C) 4 of 8 300.2210b)2) Section 300.2210 Maintenance b) Each facility shall: 2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. This requirement was not met as evidenced by: Based on observation, interview and record review the facility failed to have an operational call light system. This failure has the potential to affect all 48 residents who reside in the facility. Findings Include: The Facility’s “Resident Council Notes” dated June 2025, documents, “Call lights and bells are not working for C hall.” The Facility’s “Resident Council Notes” dated July 2025, documents, “residents say they want call lights fixed because no one responds to the bells. (I explained that maintenance has been working on call lights, but the old wiring has been an issue).” On 8/19/2025 at 9:50 AM, R7 was ringing his hand bell while he was seated on his bed inside of his room. R7 stated out loud, “is anyone out there?” “I need someone to come help me with my colostomy.” R7 continued to ring his bell until 9:54 AM when he (R7) walked with his walker to the nurses’ desk where multiple staff including CNAs and nurses were standing. R7 said something to the staff then returned to his room. At 9:58 he began ringing his hand bell again and yelling, “I thought someone was coming? I am going to have a	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 5 mess!" At 10:00 AM V8 (Certified Nurse Aide) walked onto the hallway and R7 was ringing his bell and yelling "someone come help me already!" V8 entered his room and stated, "Jeez ok, I am here." On 08/19/2025 at 10:30 AM, V8 (Certified Nurse Aide) stated that she had been on a different hallway helping another staff member and did not hear R7's hand bell until she returned to the hallway. On 8/19/25 at 1:30 PM, R3 stated that her call light works however there are several in the facility who have issues with their call lights and were given bells to ring. R3 stated, "The bell is good in theory, but the staff cannot hear them if they are not on the hall. You can't hear them at the nurse's station and barely can in the dining room so if a resident rings it and the staff are helping someone down another hallway, they can't hear them so it's not a feasible option." On 8/19/25 at 2:30 PM, V13 (Maintenance Director) stated "the call light system needs fixed. I have tried to wire the ones that aren't working but I had to tell (Corporate) I am not that good at this kind of thing, so we are getting estimates to get the entire thing fixed. We have some rooms that just don't work, we gave those residents hand bells, but then throughout the building it is inconsistent, sometimes it works, sometimes it doesn't. Sometimes the lights will turn on outside of the room but then will not light up on the main board. Sometimes the lights don't make noise and sometimes they do. The whole system needs fixed." (B) 5 of 8 300.2210b)7)8) Section 300.2210 Maintenance b) Each facility shall: 7) Maintain the grounds free from refuse, litter, insect and rodent breeding areas. 8) The building and grounds shall be kept free of any possible infestations of insects and rodents by eliminating sites of breeding and harborage inside and outside the building; eliminating sites of entry into the building with screens of not less than 16 mesh screen to the inch and repair of any breaks in construction.	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 6 This requirement was not met as evidenced by: Based on observation, record review and interview the facility failed to keep the facility free of flies and other reported insects. This failure has the potential to affect all 48 residents who currently reside in the facility. Findings Include: On 08/19/2025 at 8:00 AM until 8:40 AM continuous observation of the main dining room showed multiple residents swatting at flies with their hands. Residents were waving their hands around their plates while eating and saying things like “shoo fly” “get out of here.” Multiple flies were noted on dining room tables, residents, floors, walls. V9 (Registered Nurse) was administering medicine during this time and was also waving her hands around her face and residents faces to keep the flies away from them. On 08/19/2025 at 8:00 AM until 8:40 AM the sliding glass door that leads to the smoking patio that is directly outside of the main dining room was opened and closed multiple times by staff and residents. R1’s medical record documents she was admitted to the facility with Cerebral Palsy, Microencephaly and anorexia. R1 is rarely/never understood and cannot move with any purpose. On 8/19/2025 R1 was in the main dining room with flies on her face and mouth at 8:00-8:40 AM, 11:15 AM, 12:00 PM, 1:15 PM, and 3:00 PM. On 8/20/2025 R1 was in the main dining room with flies on her face and mouth at 8:15 AM, 10:00 AM, 1:00 PM and 2:30 PM. The Facility’s “Resident Council Notes” dated July 2025, documents, “Residents say that flies, ants, and other pests are becoming worse across the facilities (bathrooms, bedrooms, and cafeteria)." On 08/20/2025 at 1:00 PM, R1 stated that the flies “are awful.” “They keep saying oh we called the bug people.” “It doesn’t help to spray if no one takes out the trash and doesn't keep the place clean. I have been taking out the trash in the dining room in the evenings, so it won’t be sitting there collecting flies for morning.” The Facility’s “Resident Council Notes” dated July 2025 documents “Residents say that they want a night shift	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 7 housekeeper because trash, floor messes and laundry aren't getting taken care of during the night." "(R1) says she has been taking out trash in the cafeteria by the time housekeeping comes in." The Facility's "Resident Council Notes" dated 08/07/2025, documents, "Residents want a night shift housekeeper for trash, floors, tables, and bathrooms at night." (C) 6 of 8 300.1210b) 300.3210a)1)2)A)B)C)3) 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. Section 300.3210 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the resident's status as a resident of a facility. 1) Residents shall have the right to be treated with courtesy and respect by employees or persons providing medical services or care and shall have their human and civil rights maintained in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities. 2) Residents shall have their basic human needs, including but not limited to water, food, medication, toileting, and personal hygiene, accommodated in a timely manner, as defined by the person and agreed upon by the interdisciplinary team. A) A facility shall treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 8 enhancement of the resident's quality of life, recognizing each resident's individuality. B) A facility shall protect and promote the rights of the resident. C) Residents have the right to reside in and receive services in the facility with reasonable accommodation of their needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 3) Residents have the right to maintain their autonomy as much as possible. (Section 2-101 of the Act) This requirement was not met as evidenced by: Based on observation, interview and record review the facility failed to permit residents to have as much milk as they would like for lunch and supper, failed to serve alternate menu as directed, the facility also failed to assist one resident (R9) to lay down as requested causing the resident to be very upset and crying. These failures have the potential to affect all 48 residents who reside in the facility. Findings Include: On 08/19/25 during the lunch meal staff could be over heard reminding residents that they could only have one cup of milk with their lunch. On 8/19/25 at 12:15 PM, V8 (Certified Nurse Aide) stated, “It’s the kitchen’s rule, for breakfast anyone can have milk as much as they want but for lunch and supper, they can have one glass of milk and then they need to drink Kool aide, water, tea or something else.” On 8/19/25 at 1:00 PM, V4 (Dietary Manager) confirmed that she had instructed staff that residents can have as much milk as they want for breakfast but for lunch and dinner, they could only have one glass. V4 stated, “Corporate comes in and cuts my truck (food and drink supplies) and I have no control over that. I was trying to cut corners to make sure we have enough for everyone.” On 08/19/2025 during the lunch meal the following residents were served hot dogs on regular bread: R10, R11, R12, and R13. On 8/19/25 during the lunch meal R11 picked her hot dog up with her fingers and ate it. R11 stated, “I can’t see to grab the bread.” R11 was dripping ketchup down	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 9 the front of her while attempting to eat the hot dog. On 08/19/2025 around 12:15 PM, V4 (Dietary Manager) stated that the hot dogs were served on regular bread because she did not have any hot dog buns available. V4 confirmed that hot dogs are part of the “always available” menu for residents who do not want the planned meal. On 8/20/2025 at 8:50 AM, R9 was sitting in her wheelchair at a dining room table. R9 asked multiple staff members that walked by if they would help her get back to bed. Around 8:55 AM, R9 began becoming visibly upset and crying stating very loudly, “Why is this always so hard? I just want to go back to bed.” V7 (Licensed Practical Nurse), V9 (Registered Nurse), V10 and V11(both Certified Nurse Aides) all walked by R9 while she was visibly upset, crying and asking to go back to bed. V10 (Certified Nurse Aide) stated “I can’t right now” and kept walking. On 8/20/2025 at 9:05 AM, V2 (Director of Nursing/DON) asked R9 what was wrong. R9 told her (V2/DON) that she (R9) wanted to start refusing to get up for meals because no one will get her back to bed in a timely fashion. R9 stated, “I hurt, I shouldn’t have to sit here, I am done, they are laying other people down, why do I have to be last?” V2 (DON) stood behind R9’s wheelchair with her hands on the handles as if to push her then stopped and was talking about something unrelated with V3 (Licensed Practical Nurse). R9 yelled “Hey! Can we get going? Did you not hear me?” R9 was crying and very upset. R9 continually told V2 (DON) that staff did not listen to her and would not assist her. V2 (DON) pushed R9 to her room and attempted to calm her. V2 (DON) requested assistance from V10 (Certified Nurse Aide/CNA). R9 stated, “You are the one who told me no!” V10 (CNA) stated, “Nope, not me. Do you want help now?” On 8/20/2025 at 10:00 AM, R9 was lying in bed and stated she “felt much better.” “I always ask when they get me up for them to promise to lay me back down right away because my back starts to hurt. It gets frustrating when they just say no, or in a bit. It feels like they make me wait till last just because they can. I know other people need the lift, but so do I.” On 08/20/2025 at 11:10 AM, R1 stated that R9 “always has to beg” to get laid down after meals. “I think everyone’s day would go better if they would just stop what they are doing and lay her down. But I don’t think they (staff) don’t like being told what to do, so they	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 10 get to her (R9) when they want to." The Resident Census Report dated 08/19/2025 documents 48 residents currently reside in the facility. (B) 7 of 8 300.640a) 300.640k) 300.640l)1)2)3)4) 300.640m) Section 300.640 Residents' Advisory Council a) Each facility shall establish a residents' advisory council consisting of at least five resident members. If there are not five residents capable of functioning on the residents' advisory council, as determined by the Interdisciplinary Team, residents' representatives shall take the place of the required number of residents. The administrator shall designate another member of the facility staff other than the administrator to coordinate the establishment of, and render assistance to, the council. (Section 2-203 of the Act) k) The residents' advisory council may communicate to the administrator the opinions and concerns of the residents. The council shall review procedures for implementing resident rights and facility responsibilities and make recommendations for changes or additions which will strengthen the facility's policies and procedures as they affect residents' rights and facility responsibilities. (Section 2-203(d) of the Act) l) The council shall be a forum for: 1) Obtaining and disseminating information; 2) Soliciting and adopting recommendations for facility programming and improvements; 3) Early identification of problems; 4) Recommending orderly resolution of problems. (Section 2-203(e) of the Act) m) The council may present complaints on behalf of a	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 11 resident to the Department, or to any other person it considers appropriate. This requirement was not met as evidenced by: Based on interview and record review the facility failed to address concerns voiced in resident council meeting minutes. This failure has the potential to affect all 48 residents who reside in the facility. Findings Include: The Facility's "Resident Council Meeting and Agenda" policy dated 11/05/2019, documents, "The facility supports residents' desires to be involved and have input in the operation of the facility through the resident council." "The Administrator reviews the minutes and any responses from departments within the facility. Responses will be presented no later than the next council meeting. Minutes include concerns or problems; issues discussed; recommendations from the council; and follow up on prior issues." The Facility's "Resident Council Notes" dated May 2025, documents, "Residents say that a certain housekeeper gets in too big of a hurry and recently broke a piece of the dining room window and knocked over a potted plant." "Residents say that Housekeeping does a poor job on nights and weekends." "Administration: residents say they want feedback from all department grievances before each council meeting." "Residents say that CNAs (Certified Nurse Aides) don't help so they (residents) have to ask housekeeping instead." "Residents say (they) can hear nurses and CNAs at the nurse's station late at night when they're trying to sleep." The Facility's "Resident/Family Concern/Grievance Form dated 5/2/25 that was presented by V1 (Administrator) as "follow up" to any Resident Council Concerns voiced in May documents "CNAs (Certified Nurse Aides) don't help, nurse and CNAs are loud." Review and action taken by V3 (Licensed Practical Nurse) documented as "talked with CNAs and nurses." The Facility's "Resident Council Notes" dated June 2025, documents, "Residents want the CNAs (Certified Nurse Aide) and nurses to have better attitudes, call lights and bells are not working for C hall, residents find the night workers in too much of a rush, there is too many flies and ants in the hallways, B hall and C hall toilets need repaired, residents want working televisions." On 8/20/2025 at 1:30 PM, V1 (Administrator) stated that	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 12 he did not have any further documentation regarding any resident council concerns voiced in the June 2025 meeting. The Facility's "Resident Council Notes" dated July 2025, documents, "Residents want bigger portions and higher quality of food with each meal, say food is being served cold and some food is still being over cooked." "Residents say showers aren't getting done and they (residents) may go a week without a shower. One resident says they have to make complaints before getting a shower. Resident says water in B Hall and C hall is not getting warm, residents say they want working televisions in every room, residents want new flags hung from the flagpole." "Residents say that they want a night shift housekeeper because trash, floor messes and laundry aren't getting taken care of during the night, Resident council president says she has been taking out trash in the cafeteria by the time housekeeping comes in, residents want housekeeping to clean the mattresses before putting clean bedding on the mattress." "Residents say that flies, ants and other pests are becoming worse across the facility (bathrooms, bedrooms, and cafeteria.)" The Facility's "Resident/Family Concern/Grievance Form" dated 7/25/25, documents the nature of the concern as "food being served cold." The form documents the review and action taken by V4 (Dietary Manager) as "will monitor food temps." On 8/19/25 at 11:30 AM, V4 (Dietary Manager) could not provide any documentation of any extra food temperatures that were monitored as a result of the complaint in July resident council minutes. "We monitor the food (temperatures) before we serve all the time." The Facility's "Resident/Family Concern/Grievance Form dated 7/25/25, documents the nature of the concern as "male nurse on thirds, showers, CNAs rude." The form documents the review and action taken by V3 (Licensed Practical Nurse) as "stopped using the male nurse, talked with CNAs about showers, talked to CNAs about being rude." The Facility's "Resident Council Notes" dated 08/07/2025, documents, "residents claim kitchen staff refuses to make them food if they don't like their meal, residents say that they aren't getting bathed regularly, residents also say they want the kitchen staff to get the menus right, residents want a night shift housekeeper." The Facility's "Resident/Family Concern/Grievance Form"	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 13 dated 8/25 documents the nature of the concern as “need microwave and bibs, refuses to make meals.” The form documents the review and action taken by V4 (Dietary Manager) as “microwave and bibs purchased, will make alternate meals.” On 08/19/2025 at 11:30 AM, V4 (Dietary Manager) stated that she “spoke with” all of her staff about always making requested meals. V4 stated she did not determine which staff member was accused of not making a meal for what resident. “I just told them all, that we always make an alternate.” V4 stated she “hadn’t heard” any further complaints. The Facility’s “Resident/Family Concern/Grievance Form” dated 8/25 documents the nature of the concerns as “showers.” The form documents the review and action taken by V3 (Licensed Practical Nurse) as “have a shower aide now.” On 8/20/2025 at 9:30 AM, V3 (Licensed Practical Nurse) stated that she did not investigate whether residents were getting their showers as scheduled or not. “I spoke with the CNAs and told them to do their showers as scheduled.” V3 stated she “had not heard” any further complaints since designating one of the CNAs specifically to do showers. V3 stated “I don’t know who was complaining or what staff member was allegedly not giving showers as they should.” On 8/20/2025 at 1:30 PM, V1 (Administrator) confirmed that none of the “Resident/Family Concern/Grievance” forms had any information in “Section 4: for Administrator or Compliance Ethics Officer to Complete: Further action requires and/or new grievance generated, and concern and/or grievance resolved.” V1 stated, “I think I might be the grievance officer.” The Facility’s “Resident Roster” dated 8/19/2025, documents 48 residents currently reside in the facility. (B) 8 of 8 300.610a) 300.682a)1)2)3)4) 300.682b) 300.682f)1)2)3)4)5)	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 14 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 300.682 Nonemergency Use of Physical Restraints a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on: 1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective; 2) the assessment of a specific physical condition or medical treatment that requires the use of physical restraints, and how the use of physical restraints will assist the resident in reaching his or her highest practicable physical, mental or psychosocial well-being; 3) consultation with appropriate health professionals, such as rehabilitation nurses and occupational or physical therapists, which indicates that the use of less restrictive measures or therapeutic interventions has proven ineffective; and 4) demonstration by the care planning process that using a physical restraint as a therapeutic intervention will promote the care and services necessary for the resident to b) A physical restraint may be used only with the informed consent of the resident, the resident's guardian, or other authorized representative. (Section 2-106(c) of the Act) Informed consent includes information about potential negative outcomes of physical restraint use, including incontinence, decreased range of motion, decreased ability to ambulate, symptoms of withdrawal or depression, or reduced social contact. Attain or maintain the highest practicable physical, mental or psychosocial	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 15 well-being. (Section 2-106(c) of the Act) f) Whenever a period of use of a physical restraint is initiated, the resident shall be advised of his or her right to have a person or organization of his or her choosing, including the Guardianship and Advocacy Commission, notified of the use of the physical restraint. A period of use is initiated when a physical restraint is applied to a resident for the first time under a new or renewed informed consent for the use of physical restraints. A recipient who is under guardianship may request that a person or organization of his or her choosing be notified of the physical restraint, whether or not the guardian approves the notice. If the resident so chooses, the facility shall make the notification within 24 hours, including any information about the period of time that the physical restraint is to be used. Whenever the Guardianship and Advocacy Commission is notified that a resident has been restrained, it shall contact the resident to determine the circumstances of the restraint and whether further action is warranted. (Section 2-106(e) of the Act) If the resident requests that the Guardianship and Advocacy Commission be contacted, the facility shall provide the following information in writing to the Guardianship and Advocacy Commission: 1) the reason the physical restraint was needed; 2) the type of physical restraint that was used; 3) the interventions utilized or considered prior to physical restraint and the impact of these interventions; 4) the length of time the physical restraint was to be applied; and 5) the name and title of the facility person who should be contacted for further information. This requirement was not met as evidenced by: Based on observation, interview and record review the facility failed to ensure one resident (R1) was free from a physical restraint of one reviewed for a physical restraint in a total sample of 13. The Facility's "Restraints" policy dated 10/16/2023, documents, "The facility will treat all residents with respect and dignity, including, ensuring residents' right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 16 medical symptoms. When a physical restraint must be used, the Facility will use the least restrictive restraint for the least amount of time and provide ongoing re-evaluation of the need for the physical restraint." The policy also documents, "A physical restrain is any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: i. is attached or adjacent to the resident's body; ii. Cannot be removed easily by the resident; and iii. Restrict the resident's freedom of movement or normal access to his/her body. The Facility's "Restraints" policy dated 10/16/2023 documents "Documentation: a. as the use of any physical restraint is limited to circumstances in which the resident has medical symptoms that warrant the use of restraints, the facility shall identify and document the medical symptom being treated and an order for the use of the specific type of restraint. B. A medical practitioner's order alone (without supporting clinical documentation) is not sufficient to warrant the use of the restraint. C. The facility is accountable for the process to meet the minimum requirements of the regulation including: i. appropriate assessment; ii. Care planning by the interdisciplinary team, and iii. Documentation of the medical symptoms and use of the physical restraint for the least amount of time possible. R2's Medical Record documents that she was admitted on 4/22/2024 with diagnosis to include but not limited to Cerebral Palsy, Microcephaly and anorexia. On 8/19/2025 at 8:30 AM, R2 was in a custom reclining wheelchair. R2 had a seat belt in place across her lower abdomen. R2 was unable to comprehend and/or answer any questions when spoken to. R2's Physician Order Sheet dated August 2025 documents "Mandatory seat belt when up in chair for safety." On 8/19/2025 at 1:30 PM, V7 (Licensed Practical Nurse) confirmed she was the nurse who called V17 (Doctor) to request an order for R2's seat belt. "I started here about 3 months ago and she was wearing it (seat belt) so I made sure that I called the doctor and got an order for it, we cannot have a restraint without a doctor's order." V7 reported "safety concerns" as the reasoning for the seat belt, "she's in that high chair, if she falls that is a long way to go." V7 then confirmed that she did not know of any times that R2 had fallen out of her wheelchair. "She can be squirmy when she laughs."	S9999		

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 08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE CARE CENTER	400 WEST GRANT STREET , MACOMB, Illinois, 61455

(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) COMPLETION DATE
S9999	Continued from page 17 On 08/19/2025 at 3:00 PM, V2 (Director of Nursing) confirmed that R2's medical record did not include any restraint assessment, any documentation of concerns that would warrant the use of a physical restraint, and that there was no consent obtained from R2's Health Care Power of Attorney. V2 also confirmed that R2 is rarely or never understood and could not remove the seat belt on her own. (B)	S9999		