STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ______ B. WING ______	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	**1635 EAST 154TH STREET DOLTON, IL 60419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F 309	Continued From page 13 of their final report. The facility denied E5 was abusive but terminated E5 for failure to follow policy. The report stated, "However the employee was terminated because he failed to use the proper technique when trying to de-escalate the resident. He used poor judgement and contained the resident to long for her to calm down."	F 309		
F9999	FINAL OBSERVATIONS 300.3240a) 300.3240e) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) Based on record review and interviews the facility failed to follow policy and procedure by allowing E5 (social worker) to continue to work after other residents reported that he had been abusive to R 1 on December 7, 2005. The allegation was reported to nursing staff by residents, however E 5 continued to work. An investigation was not	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ______ B. WING ______	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	**1635 EAST 154TH STREET DOLTON, IL 60419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 14	F9999		

initiated until the next day, December 8, 2005.

R1 is a 61 year old female resident with the following diagnosis: Schizo Affective Disorder, Depression, Paranoid, Diabetes, Hypertension and Asthma. R1 was readmitted to the facility July 7, 2005 after a psychiatric hospitalization. R 1's last MDS (Minimum Data Assessment) was dated October 26, 2005 and the last care plan was dated October 27, 2005. R1's MDS indicates that the resident had no behavior problems and has moderately impaired decision making ability. The MDS also indicates that the resident does need supervision in areas of hygiene and does have some mood issues. The care plan for most areas was updated and revised on October 27, 2005, however the psycho-social areas were not updated. The care plan dated July 27, 2005 does discuss R1's delusions and hallucinations in addition to a discussion of R1's problem of making false accusations. A review of nursing and social service notes in the medical record indicate no discussion of R1 making false accusations and or having physically aggressive behavior. R1's care plan does not discuss the need to use a physical restraint for behavior interventions.

E1 (administrator) was notified by E3 (Clinical Director) on December 8 of resident complaints about E5 being abusive to R1. According to the facility's incident report, several residents approached E3 about the behavior of E5 the previous evening. The incident report states, " Administrator was informed on 12-08-05 by E3 that she was approached by several residents complaining that counselor (E5) was physically abusive to R1)." Surveyor interviewed E1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ______ B. WING ______	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	**1635 EAST 154TH STREET DOLTON, IL 60419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 15	F9999		

December 9, 2005 at 11:00 A.M. and E1 stated that she had reported the incident to Public Health and that the facility was in the process of conducting an investigation. According to E1, the employee (E5) was notified not to return until the investigation was complete.

E3 was interviewed December 9, 2005 at 11:35 A .M. E3 stated that she was approached by residents telling her that E5 was rough with R1. E3 stated that she was concerned due to the number of residents who approached her. E3 also stated that the residents complaining were high functioning and she felt reliable. E3 stated she then immediately informed E1 and the facility initiated an investigation.

R1 was interviewed December 9, 2005 at 12:00 P.M. R1 stated "He [E5] took my cigarette and my pop and threw it on the floor. He was threatening, E4 [nurse] begged him to stop" "he had a choke hold on me, he raised his voice" "E 4 begged him to turn me loose, E4 told me to go to my room" "Other residents witnessed this." R 1 also stated she was "afraid and felt unsafe."

R2 was interviewed 12:20 P.M. on December 9, 2005. R2 stated that R1 was smoking in the wrong area of the facility and E5 wanted her to move. R2 stated that E5 grabbed R1 from behind and went towards the door towards the nursing station. R2 stated, "he was rough, it bothered me that he was rough." R2 also stated that she did not witness R1 hitting or being physically abusive towards E5. R2 stated that R1 was swearing and cussing but R1 was not physically aggressive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ______ B. WING ______	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	**1635 EAST 154TH STREET DOLTON, IL 60419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 16	F9999		

R3 was interviewed at 1:45 P.M. on December 9, 2005. R3 stated that E5 had R1 from behind and pushed R1 down the hall to the nursing station. R3 stated that E5 was rough with R1 and still had a grip on her at the nursing station. R3 stated, " He has an attitude, we should not be treated that way, R1 should not have been treated that way, I also told E3 about this". R3 also stated that the residents went to E4 about the incident and she tried to find out what had happened.

R4 was interviewed at 12:40 P.M. on December 9, 2005. R4 stated that E5 was trying to talk with R1 and she attempted to hit E5. According to R4 , E5 tried to hold down R1's arms and took her to the nursing station. R4 stated he did not see anything else.

R5 was interviewed at 2:20 P.M. on December 9, 2005. R5 stated that R1 was smoking in the wrong area and when E5 approached her about this, she began swearing at E5. E5 then grabbed R1 from behind so hard he lifted her up off the chair. R5 stated that the residents told E4 about this and she was asking everyone about the incident. R5 stated that E5 was "over the top, R 1 was yelling to let me go". R5 stated that E5 continued to work the rest of the shift.

E5 was interviewed by phone December 9, 2005 at 3:00 P.M. E5 stated R1 was smoking in the wrong area of the dining room and when E5 asked E1 to move she started to swear. E5 stated that he asked R1 several times to move and she refused. E5 also stated he did not remember if R1 hit him or not. E5 stated, "E8 (Nursing Aid) told me she hit me but I don't remember." E5 then stated that he was afraid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ____ B. WING ____	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	1635 EAST 154TH STREET DOLTON, IL 60419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 17 that R1 would spill Cherry Soda on him so, "I held her wrist and put her pop on the table, I folded arms around waist and walked her to the nursing station." The nursing staff took her to her room. E5 stated that he had been employed by the facility since August 8, 2005 and had experience as a social worker. E8 was interviewed by phone December 8, 2005 at 1:35 P.M. E8 stated that R1 was smoking in the wrong area of the dining room, and refused to move. According to E8 when E5 grabbed the cigarette out of R1's hand she had a reflective action and hit E5 on the shoulder, and never hit E 5 again. E8 stated, "it was a reflex after E5 snatched the cigarette". E8 stated that E5 did what he did because, "didn't want the other residents to take control". E8 stated that E5 went behind R1 and restrained her and went to the nursing station. E8 stated that he did remember that E4 told E5 to let R1 go. E8 stated, "I wanted to help E5 but he said, I've got it". According to E 8, R1 is normally quite and when she gets moody the best solution is to leave her alone. E7 (nursing aid) was interviewed by phone December 14, 2005 at 10:20 A.M. E7 stated that she did not witness R1 hitting E5 but heard the noise. E7 stated, "I saw her being held at the nursing station, went to close the doors to keep the other residents out and heard E4 telling E5 to let her go". "I think he (E5) should have let R1 alone and let the nurse deal with R1. E5 doesn't know R1 the way we do." "R1 always gets like this around the holiday season, I usually just ignore her." E4 (nurse) was interviewed December 7, 2005 by	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ______ B. WING ______	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	**1635 EAST 154TH STREET DOLTON, IL 60419**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 18	F9999		

phone at 2:35 P.M. E4 stated that she did not witness the incident in the dining room, but E5 was restraining the resident from hitting him. E4 stated that she asked E5 to let R1 go and he did not. E4 stated that R1 was pretty upset and that E5 finally let her go and she walked down to her room. E4 stated that she was trying to get an order for a medication for R1. E4 did not witness R1 attempting to hit E5 and stated that the residents in the dining room at the time were alert and reliable and they told me E5 was restraining R1. E4 stated that normally R1 gets along with people. E4 stated she gave R1 some medication and talked with her and she calmed down.

E1 was interviewed during the daily status meeting of December 9, 2005 at 3:30 P.M. E1 stated that had she been aware of the incident, she would have sent the employee (E5) home until the incident could be investigated further.

Z1 (Psychiatrist) was interviewed by phone December 15, 2005 at 1:45 P.M. Z1 stated that R1 had been admitted to the hospital after the incident. Z1 stated that R1's main problem is medication non compliance and she had not known the resident to be physically abusive only verbally. Z1 also stated, "She responds better to some staff than others, when she is paranoid its better just to leave her alone." "I don't understand the need for the physical restraint."

The facility's policy for Behavioral Emergencies was reviewed. The policy states, "The use of non -violent crisis intervention techniques/CPI therapeutic hold is permissible only when situation is not managed with the use of verbal de -escalation techniques." The facility policy also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145798	A. BUILDING ____ B. WING ____	C 12/16/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYSIDE HEALTHCARE CENTER	1635 EAST 154TH STREET DOLTON, IL 60419

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
F9999	Continued From page 19 states that all effort should be used to de-escalate a situation with verbal techniques and other non threatening techniques. The facility provided the department with a copy of their final report. The facility denied E5 was abusive but terminated E5 for failure to follow policy. The report stated, "However the employee was terminated because he failed to use the proper technique when trying to de-escalate the resident. He used poor judgement and contained the resident to long for her to calm down." The facility failed to immediately remove an employee from active duty after an allegation of abuse was voiced by residents. The employee, E5, was allowed to work the entire shift violating the facility policy that states, "immediately protecting residents involved in identified reports of possible abuse" and "implementing systems to investigate all reports and allegations of mistreatment promptly and aggressively."	F9999		