| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Final Observations<br><br>Statement of Licensure Violations<br><br>300.1210b)<br>300.1210d)6)<br>300.3240a)<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>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:<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a | S9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 1 | S9999 | | |

resident.

These Regulations were not met as evidenced by:

Based on observations. interview and record review, the facility failed to provide appropriate supervision and ensure safety measures were in place and failed to do a thorough investigation into the falls/injuries and failed to determine the root cause of the falls/injuries for 3 (R1, R2, R3) of 3 residents reviewed for falls/injuries in the sample of 3 residents. This failure resulted in all 3 residents requiring sutures/staples to the head. R1 received 10 staples to the head, R2 received 3 sutures to the eyebrow and R3 received 2 staples to the head.

The findings include:

On 3/27/14 at 2:16 PM, R1 was seated in his wheel-chair outside his room in hallway. The vinyl covering on the bilateral armrests of the wheel-chair were extensively ripped exposing the padding. R1's legs were stretched outward, he had long dirty finger nails and kept saying "what am I doing?". R1 had 12 metal staples on the top of head toward his left side. R1 was very confused, disoriented and stated not to be in pain. R1 stated not to remember anything.

The facility's incident report dated 3/20/14 at 12:12 PM documents R1 was being transported via an outside agency van escorted by facility staff member, E4 (certified nurse aide). As the van exited the road onto a ramp, R1 and R1's wheel-chair fell to the left. R1 sustained a laceration to the left side of his head. R1 was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 2 | S9999 | | |

immediately taken to the hospital where he received 10 staples to the head. The report included 2 statements, one from Z1 (van driver) and other from E4. Z1's statement dated 3/20/14 documents as the van exited the road onto a ramp, the wheel-chair released R1 who fell and hit his head on a object in the vehicle. Z1 documents that E4 was sitting up front with Z1. Z1 documents R1 was bleeding and taken to the hospital.

E4's written statement date 3/20/14 documents Z1 secures R1 in the van and E4 rode up front with driver, Z1. Z1 makes another stop to pick up 2 other individuals in which he needs to move R1 so he can fit the other 2 individual in the van. Z1 first drops off the other 2 individuals. As the van exited the road onto a ramp, the van comes to stop due to a stop sign. Z1 hits the gas as the van is turning left causing R1's wheel-chair to flip over to the side. The van stopped and E4 got out of the front seat and assisted R1. R1 was bleeding so he was taken to the hospital. Both Z1 and E4 assisted R1 into the hospital.

R1's hospital report dated 3/20/14 documents R1 received 2 sutures used to repair galea and 10 staples used to the scalp.

The hospital cat scan on the head dated 3/20/14 documents a right temporal parietal craniotomy with surgical clips seen in the region of the right posterior frontal temporal junction in the mid to low convexity but no hemorrhage or extra-axial fluid collection. R1's care plan does address R1 having had a craniotomy procedure but unsure of the time-frame.

There was no other documentation provided nor did the facility do a thorough investigation to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 3 | S9999 | | |

determine if R1 and his wheel-chair were secured in the van.

The facility's work description labeled Transportation Aid documents the primary purpose of this position is to assist residents as needed with transportation to and from outside appointments and provide nonprofessional nursing care, monitoring and simple technical nursing services during these trips. The duties also include to ensure resident are safely secured in vehicle and to ensure the vehicles is clean, safe and in good working condition, such as, safety belts. Monitor and supervise residents in transport to assure safe travel. Follow all rules of the road and drive in a prudent and safe manner. Ensure all equipment used by resident, such as, wheel-chair is in good working condition.

R1's care plan dated 1/20/14 documents potential for trauma, falls and injury as a problem. The approaches are to maintain safety and anticipate resident's needs. The care plan is updated on 3/20/14 but the approaches remain the same. The care plan also addresses R1's prone to uncontrolled bleeding as a problem due to R1's use of heparin and the potential for neglect. The approaches under neglect document to check positions when transferring or repositioning.

R1's current (March 2014) physician order sheet documents R1 is to receive 5000 units of heparin every 12 hours. In addition, there is an order dated 3/20/14 to remove R1's 10 staples in 10 days.

R1's quarterly Minimum Data Set (MDS) dated 1/14/14 document R1 to have BIMS (brief interview mental status) of "1" which indicates he is severely confused and disoriented. R1 required

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 4 | S9999 | | |

total to extensive assistance of one person for ambulation and transfers.

On 3/27/14 at 2:05 PM in the hallway outside of the large dining room, R2 was standing but slightly wobbly so we both moved closer to the wall so she could use the hand rail if needed. R2 pointed to her right eye brow. There was a little bump on the upper portion of the right eye socket and a half inch indentation on the right eye brow. R2 stated it hurts still. R2 stated she was standing in her room and all of sudden she falls hard and started bleeding from the head. R2 stated she then went to the nurse and told her what had happened. R2 stated she was sewn up but the area still bothers her.

R2's nurses notes dated 2/21/14 documents R2 had a physical altercation with another peer and hit him because she thought he was talking about her. R2 was sent out to the hospital for an evaluation and did not return until 3/4/14.

Nurses' notes and the facility's occurrence report dated 3/5/14 documents R2 coming to the nurses' station at 7:30 PM and saying she fell this morning and hit her head and arm. R2 was found to have a scabbed area and a purplish, deep red area on the right side of forehead and purplish deep red area to the right outer eye. The recommendation for R2 was to use a wheel-chair for unsteady gait and to report incident as soon as possible and send to physical therapy for evaluation.

There was no other documentation presented such as possible witnesses and why the assigned nurse's aide did not notice the bruising.

Nurses' notes and facility's occurrence report

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 5 | S9999 | | |

dated 3/6/14 document at 11 AM R2 stood up from wheel-chair to get coat and lost her balance and fell. The fall was witnessed by R4, R2's room-mate but there was no written statement provided by R4 nor does the report document whether R4 is orient times three. The recommendations are to give R2 a seat belt for the wheel-chair, encourage her to ask for help and to dangle her feet at the side of the bed prior to standing up.

The facility's incident report and the occurrence report dated 3/9/14 at 2 PM document R2 was ambulating without staff assistance which resulted in a fall. R2 sustained a laceration to the right eye brow area.

The incident report was lacking statement from staff as to the last time R1 was seen prior to the fall, what may have caused her to sustain the injury, and where did R2 fall, where was the supervision for R2, what interventions, if any, were in place.

Nurse' note dated 3/9/14 documents R2 was found with 1/4 inch laceration to right eyebrow with small amount of bleeding. R2 was sent out to the hospital.

Nurses' note 3/10/14 documents R2 returned with 3 sutures to the right eyebrow.

The recommendation/resolution for the occurrence on the facility's incident report documents to remind resident on the importance of using the call light, bed in lowest position and floor mats in place.

R2's care plan dated 1/16/14 and 3/10/14 document potential for falls as a problem. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 6 | S9999 | | |

approaches are observe gait, evaluate foot wear, provide increased assistance and maintain safety. The wheel-chair with a safety belt was added as approach after the 3/9/14 fall.

On 3/27/14 at 2:30 PM, R2's bed was low but there were no alarms or floor mats present in the room.

R2's nurses' notes 3/13/14 documents R2's refusal to use wheel-chair due to her unsteady gait.

Nurses' note 3/16/14 documents R2's has altered mental status and is sent out to the hospital.

R2's hospital report on bilateral carotid imaging done on 3/17/14 to rule out syncope documents normal carotid imaging and Doppler spectral blood flow analysis.

The facility failed to determine the root cause of the falls and failed to provide adequate supervision.

On 3/27/14 at 2:10 PM, R3 was seated in a wheel-chair outside his room. R3 was very confused, disoriented and lethargic. R3 was wearing a soft helmet. E3 (director of nursing) was present and stated the helmet is for spastic movement. E3 instructed E5 and E6, both nurses' aides to put R3 back to bed due to him being lethargic.

On 3/27/14 at 2:20 PM, R3 is in bed. The bed is low to the floor and the length of the bed is parallel and against the wall. There are mats secured to the wall and a floor mat on the other side of the bed. R3 is sleeping and the soft helmet has been removed and put on the bed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 7 | S9999 | | |

above R3's head. The head and foot boards are made of mesh-like material.

The facility's incident report and the occurrence report dated 1/29/14 at 5:30 AM document that R3 was placed on a mattress which was on the floor due to abnormal and spastic movements associated with his disease process. R3 raised head and hit it on the bed frame. R3 was sent out to the hospital and returned with 2 staples to the top left side of the head. The incident report does not go into detail as to how the staff ensured R3's safety and how R3 was able to hit his head on bed frame. There are no written statements from staff and it is not clear if it was witnessed by anyone.

R3's quarterly MDS dated 2/18/14 documents his active diagnoses to include Huntington's Chorea and Schizophrenia. R3 is cognitively moderately impaired and requires extensive to total assistance of one staff person for transfers, ambulation, eating, dressing and hygiene.

R3's care plan with dates of 2/13/14, 2/19/14 and 3/3/14 does not address his jerky movements and the need for the soft helmet.

There is a physician order dated 1/21/14 on the March 2014 Physician Order Sheet that instructs to use the soft helmet on R3 when up in wheel-chair.

The occurrence resolution on the incident report documents R1 was given a low bed with a plastic frame. Will continue the floor mats and wall mats.

Facility staff failed to ensure safety measures were in place to protect R3's head during spastic, jerky movements.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6002190 | A. BUILDING: _____ B. WING _____ | C 04/04/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COUNTRYSIDE NURSING & REHAB CTR | 1635 EAST 154TH STREET DOLTON, IL 60419 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S9999 | Continued From page 8<br><br>On 3/27/14 at 12:40 PM, E3 (director of nursing) stated it can be anyone to complete the incident reports. E3 stated they use to have a quality assurance nurse who looks over the incidents.<br><br>On 4/4/14 at 1:55 PM, E2 (assistant administrator) stated the facility has been without a quality assurance nurse since November 2013. At 2:05 PM, E3 (director of nursing) stated they do have a part-time quality assurance nurse, E7, who works 3 days a week, 8 hours per day.<br><br>The facility's Accidents and Incidents Policy documents it is the responsibility of the D.O.N./Designee to investigate and ensure appropriate completion, notification and follow-up on all accidents and incidents. It is the responsibility of the Incident Review/quality assurance team to review incidents on a weekly basis.<br><br>The facility's policy labeled Falls Management Program documents that interventions for the prevention of falls will be individualized to meet the specific needs of the resident. A determination will be made regarding the equipment needs of the resident. A care plan will be implemented that identifies the risk and provides staff with interventions to prevent falls. Interventions will be reviewed and the care plan adjusted as needed.<br><br>(A) | S9999 | | |