

Illinois Department of Public Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002174 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/30/2015 | |
|--|--|---|---|--------------------|
| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE CENTRE | | STREET ADDRESS, CITY, STATE, ZIP CODE 2330 WEST GALENA BOULEVARD AURORA, IL 60506 | | |
| (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 | <p>Final Observations</p> <p>Statement of Licensure Violations</p> <p>300.610a) 300.1210b) 300.1210d)6) 300.3240a)</p> <p>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.</p> <p>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. Restorative measures shall include, at a minimum, the following procedures:</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour,</p> | S9999 | <p>Attachment A Statement of Licensure Violations</p> | |

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

10/09/15

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002174 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/30/2015 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE CENTRE | STREET ADDRESS, CITY, STATE, ZIP CODE 2330 WEST GALENA BOULEVARD AURORA, IL 60506 |
|--|---|

| (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 | <p>Continued From page 1</p> <p>seven-day-a-week basis:</p> <p>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.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to follow their "Safe Patient Lifting Policy" resulting in a resident fall with a fracture. This applies to R1, one of three residents reviewed for falls in the sample of three.</p> <p>The findings include:</p> <p>According to the face sheet in the medical record R1 is a 78 year old non-ambulatory female with diagnoses including rheumatoid arthritis, abnormal posture and morbid obesity. According to the quarterly MDS (Minimum Data Set) dated 08/18/15 R1 is coded as a total assist for transfers with 2 plus staff to assist. A transfer evaluation was completed on 07/16/15. The recommendation was the use of a mechanical lifting device with two staff required for transfer to and from bed to chair, chair to chair or toilet to chair.</p> <p>A facility Incident Report of 09/12/15 concluded that during transfer of R1 to bed the sling on the</p> | S9999 | | |
|-------|--|-------|--|--|

Illinois Department of Public Health

| | | | |
|--|--|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002174 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 09/30/2015 |
|--|--|---|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER COUNTRYSIDE CARE CENTRE | STREET ADDRESS, CITY, STATE, ZIP CODE 2330 WEST GALENA BOULEVARD AURORA, IL 60506 |
|--|---|

| (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 | <p>Continued From page 2</p> <p>mechanical lift tore and ripped. Staff member, E1, CNA (Certified Nurses Aid) lowered R1 to the floor. R1 was sent to the Emergency Room where an x-ray showed a fracture to the right distal humerus.</p> <p>On 09/25/15 E2 (Administrator) stated R1 was being transferred on 09/12/15 with only one staff member present. E2 stated R1 requires two staff members for transfers and E1 did not provide an explanation for transferring R1 by himself. Facility policy titled "Safe Lifting Policy" notes that transfers will be designated into five categories. The fifth category, "T"= Total Lift Transfer (mechanical lift type) with two or more caregivers (Total Assist). The policy also notes "Laundry staff and all staffing with patient contact will conduct inspection of slings; if slings are found to be impaired then sling is to be removed from use." On 09/25/15 E2 provided the sling that had torn while R1 was being transferred. The upper seam that was torn from the strap was inspected along with the rest of the straps. Signs of wear were also found on another of the intact seams.</p> <p>R1 was observed on 09/25/15 sitting in wheelchair in the dining room. R1 had a cast with a sling to the right upper extremity. When asked what happened to her R1 stated, "He dropped me". Z1 (attending physician) stated on 09/30/15 she was aware of the incident that occurred on 09/12/15. Z1 said she was not familiar with all of the details of the incident or that R1 had been transferred by only one staff member when the incident occurred.</p> <p>(B)</p> | S9999 | | |
|-------|--|-------|--|--|