STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S 000	Initial Comments Complaint 2227271/IL151105	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)1)2)3) 300.1210d)5) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's	S9999	**Attachment A** **Statement of Licensure Violations**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 1 physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 2 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. 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: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) 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) These Regulations were not met as evidenced	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 3 by: Based on record review and interview the facility failed to monitor a pressure ulcer and failed to perform wound care as ordered on a pressure ulcer for three residents (R1, R2 and R3) reviewed for pressure ulcers. These failures caused R1's wounds to deteriorate and increase in size and depth. R1's wounds required hospitalization due to extensive necrosis requiring emergent debridement. Initiation of vasopressor (IV medication that elevates blood pressure) support due to septic shock secondary to infection from a severe breakdown of the debrided wound. Findings Include: The Facility's "Decubitus Care/Pressure Areas" Policy dated 01/2018 documents "It is the policy of this facility to ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer." "The pressure area will be assessed ad documented on the Treatment Administration Record or the Wound Documentation Record." "Complete all areas of the Treatment Administration Record or Wound Documentation Record. i.) Document size, stage, site, depth, drainage, color, odor, and treatment (upon obtaining from the physician.)" Documentation of the pressure area must occur upon identification and at least once each week on the TAR or Wound Documentation Form. The assessment must include: i.) Characteristics (i.e. size, shape, depth, color, presence of granulation tissue, necrotic tissue, etc.) ii.) Treatment and response to treatment." 1. R1's "Nursing Admission Assessment" dated	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 4 8/24/22 documents R1 was admitted to the facility with the following wounds: right outer big toe area 4 cm (centimeters) by 1.8 cm; under big toe area fluid filled blister 2.5 cm by 2 cm; left heel wound open with fluid filled blister to outer peri wound; right outer heel 2.5 cm by 2.2 cm; right outer foot area 2 cm by 1 cm. R1's Nurse's Notes dated 8/24/22 document "sacrum wound" measured 14 cm by 9 cm at the top, 5.5 cm at the bottom. "Other sacrum wound: measured 8.5 cm by 5 cm. "Resident refused measurements of legs." On 9/13/22 V3 (Assistant Director of Nursing) stated "I don't know what the nurse meant by 5.5 cm on the bottom." V3 could not determine which sacrum wound was which with the measurements provided. R1's Nurse's Notes dated 8/25/22 documents " left buttock .7 cm by 8 cm by 6.1 by 4 cm depth; right buttock 2 cm by 8 cm by 2 cm depth; outer big toe .5 cm by 2 cm; left heel 9 cm by 3 cm by .4 cm." R1's Nurse's Notes document R1 was admitted to the hospital on 9/8/2022 for a bowel obstruction. R1's Hospital Record shows on 9/9/22 V4 (Registered Nurse/Certified Wound Nurse) documents "(R1) was seen by this nurse for wound vacuum placement on 8/22/22 and 8/24/22 and all wounds present have shown major deterioration." V4's documentation shows wounds on 9/9/22 to measure: left buttock 6 cm by 7 cm by .8 cm, coccyx/sacral wound 15 cm by 10.5 cm by 4.6 cm." R1's Treatment Administration Record for August	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 5 24-August 31 documents "chair cushion at all times while sitting, flex protective boots at all times unless transferring." The treatment does not have any times assigned to sign it off. One nurse signed it off on 4 days in August. R1's Treatment Administration Record for August 24-August 31 documents "moist saline gauze to left heel twice daily." The treatment does not have any times assigned to sign it off. One nurse signed it off on 4 days in August." R1's Treatment Administration Record for August 24-August 31 documents "foam to all other wounds to bilateral feet and heels." The treatment does not have any times assigned to sign it off. One nurse signed it off on 4 days in August." On 9/13/22 V3 (Assistant Director of Nursing) confirmed that R1's treatments should all have a frequency to do the treatment and V3 also confirmed these treatments were not signed off as completed. R1's Treatment Administration Record for August 24-August 31 documents "turn every 2 hours while in bed; alternating air pressure mattress at all times." The treatment does not have any times assigned to sign it off. One nurse signed it off on 4 days in August. R1's Treatment Administration Record for August 24-August 31 documents "Limit one hour up before lying down." The treatment does not have times assigned to sign it off. On nurse signed it off on 4 days in August. On 9/13/22 V3 (Assistant Director of Nursing) could not provide September Treatment Administration Records for R1. "They haven't	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 6 even been put out yet." On 9/13/22 V3 (Assistant) Director of Nursing) stated "(R1) was supposed to start seeing our wound doctor but the last time he came back from the hospital we saw that he had an appointment with a dermatologist so we figured they would handle his wounds." On 9/13/22 V6 (Dermatology Nurse Practitioner) stated "We saw (R1) for a routine follow up regarding melanoma, we do not address wounds in long term care, they usually have their own wound doctors who take care of that." R1's hospital record/Doctor Progress note from V6 (Surgeon) at hospital dated 9/9/22 documents" Patient is a 60 year old male with multiple medical comorbidities on coumadin, (blood thinner) for history of Pulmonary Embolism, who is known to the surgery service. Patient has a stage 4 sacral decubitus ulcer that was debrided a couple of weeks ago due to necrosis, and now presents back to the hospital due to lethargy and altered mental status. When he arrived he was found to be tachycardic and hypotensive, requiring initiation of vasopressor support due to septic shock secondary to infection from a severe breakdown of the debrided wound. After his last hospitalization he was discharged to (The Facility) and was supposed to have his wound managed with a wound vac. The wound vac was reportedly not being used and patient was not participating in any activity or physical therapy, and now has extensive necrosis requiring emergent debridement." On 9/14/22 V5 (RN/Case Manager at hospital)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 7 stated "The condition (R1)'s wounds was visibly deteriorated. The dressing they (the nurses) took off of him in the emergency room wasn't even all the way on and it was rolled up and to the side and it had been that way for a while due to the amount of debris and drainage that was on the dressing." 2. R2's "Nursing Admission Assessment" dated 6/17/22 documents "1/2 inch open area" to right thigh. R2's "Wound Doctor" progress notes documents measurements of right thigh wound on 7/11/22, 7/18/22,7/25/22, and 8/8/22 show .5 cm (centimeters) by .4 cm by .2cm. R2's Treatment Administration Record for September 2022 documents "Alginate Calcium with silver and border gauze to right groin." The Treatment Administration Record shows "6-2" shift responsible for this treatment. The treatment is not signed off as done for the month of September (9/1/22 until present 9/13/22.) 3. R3's "Nursing Admission Assessment" dated 12/23/2017 documents 3 cm (centimeters) by 4 cm reddened area to her coccyx. R3's "Wound Doctor" progress notes documents measurements of coccyx wound measurements to coccyx wound on 4/19/22 1.5 cm (centimeters) by .5 cm by .2 cm; 5/10/22 1.5 cm by 2cm by .3 cm; 5/24/22 2 cm by 2 cm by .3 cm; 6/7/22 2 cm by 2 cm by 2 cm; 6/14/22 2 cm by 2 cm by 2 cm; 7/11/22 1.7 cm by 2 cm by 5 cm; 7/18/22 1.7 cm by 2 cm by 5 cm, 7/25/22 1.5 cm by 1.8 cm by 2 cm; 8/8/22 1cm by .9 cm by 2 cm and 8/22/22 .7 by 1 by unmeasurable depth.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005631	A. BUILDING: _____ B. WING _____	C 09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRYVIEW CARE CENTER-MACOMB	400 WEST GRANT STREET MACOMB, IL 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) COMPLETE DATE
S9999	Continued From page 8 On 9/13/22 V3 (Assistant Director of Nursing) could only provide July 2022 Treatment Administration Record which did not have any treatments to be done on it. On 9/13/22 V3 (Assistant Director of Nursing) stated "(R3) has had this area since May it looks like, so there should be TARs for her with the treatment we are doing on it, but I cannot find them." On 9/13/22 V3 (Assistant Director of Nursing) stated "We do not have a wound nurse, we go off of the wound doctors sizes and description of wounds. There have been holidays that the wound doctor does not come in, so we miss those weeks, or if she (Wound Doctor) could not come to the building for whatever reason, then we would not have measurements for those weeks." V3 confirmed that wounds were not measured and described in detail for all three residents (R1, R2 and R3) on a weekly basis. V3 also confirmed the lack of documentation regarding wound care treatments for all three residents."(R1, R2 and R3) (A)	S9999		