Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ANDPLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: ___ COMPLETED C IL6005631 B. WING 06/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 WEST GRANT STREET** COUNTRYVIEW CARE CENTER-MACOMB MACOMB, IL 61455 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (X5)(EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) SOOO **Initial Comments** S 000 Complaint 2224493/IL 147779 S99991 **Final Observations** S9999 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)2)3) 300.1210d)6) 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 300.1210 General Requirements for Nursing and Personal Care Attachment A The facility shall provide the necessary Statement of Licensure Violations care and services to attain or maintain the highest practicable physical, mental, and psychological Illinois Department of Public Health

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

TITLE

(X6) DATE

Illinois	Department of Public	Health				FOR	M APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
		A. BUILDING:			COMPLETED			
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NAMEO	E PROVIDER OR CURRY IER					06/10/2022		
	F PROVIDER OR SUPPLIER	***		Y, STATE, ZIP CODE				
COUNT	RYVIEW CARE CENTE	MACOM	ST GRANT B, IL 6145					
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DE	(X5) COMPLETE DATE		
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	well-being of the res	sident, in accordance with						
	each resident's com	Drehensive resident care						
	plan. Adequate and	properly supervised nursing					13	
	resident to meet the	are shall be provided to each total nursing and personal						
	care needs of the re	sident. Restorative		. *				
	measures shall inclu	ide, at a minimum, the						
	following procedures	5:	1					
	c) Each direct of	care-giving staff shall review						
	i and be knowledgeat	ole about his or her residents!]					
	respective resident of	care plan.						
	2) All treatment administered as order	s and procedures shall be ered by the physician.						
	l ·		l					
	 Objective obstesident's condition, 	servations of changes in a						
	emotional changes, a	as a means for analyzing and					Ca 54	
	determining care req	uired and the need for						
9	made by nursing staf	ation and treatment shall be						
	resident's medical re-	cord.						
	d) Pursuant to s	ubsection (a), general lude, at a minimum, the		,				
j	following and shall be	practiced on a 24-hour						
1	seven-day-a-week ba	isis:						
1						,		
	6) All necessary	precautions shall be taken				•		
	to assure that the resi	idents' environment remains						
	as free of accident ha	zards as possible. All						
- 1	that each resident rec	all evaluate residents to see eives adequate supervision				- 1		
	and assistance to pre-	vent accidents.						
	•			,		,		
	Section 300.3220 Med	tical Core		• .				
		Jivai Care		,				

Ilinois Department of Public Health

Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C IL6005631 B. WING 06/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 WEST GRANT STREET** COUNTRYVIEW CARE CENTER-MACOMB MACOMB, IL 61455 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 2 S9999 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 by: Based on interview and record review the facility failed to ensure physician ordered X-rays were obtained for one (R1) resident reviewed for falls. This failure resulted in continued pain for R1 and a four day delayed treatment of R1's left hip and left wrist fractures which required hospitalization. Findings include: The facility Fall Prevention policy and procedure, revised 11/10/18, documents "Immediately after any resident fall the unit nurse will assess the resident and provide any care or treatment needed for the resident." The A.I.M. for Wellness form for R1, dated 6/2/22 at 2:15 am, documents R1 fell going to the bathroom without using her wheeled walker and complained of pain to her left forearm and back. This form documents R1's PCP (Primary Care Physician) was notified and X-rays were

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C IL6005631 B. WING 06/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 WEST GRANT STREET** COUNTRYVIEW CARE CENTER-MACOMB MACOMB, IL 61455 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) S9999 Continued From page 3 S9999 requested for R1's left forearm and back. The Nurses Note for R1, dated 6/2/22 at 10:00 am, documents R1 refusing to stand or walk due to complaints of pain. R1's PCP was notified due to resident now complaining of left hip and left foot pain. The Nurses Note for R1, dated 6/3/22 at 12:00 pm, documents "New order received for X-rays post fall." The POS (Physician Order Sheet) for R1, dated 6/3/22, documents a Physician Order for X-rays of R1's left forearm, back, left hip and left foot due to post fall pain and limited mobility. The Nurses Note for R1, dated 6/6/22 at 1:00 pm, four days after R1's fall, documents "(diagnostic service) coming today to complete X-rays." The (diagnostic service) X-ray results dated 6/6/22 document results of left hip X-ray as "Left femoral neck fracture" and left forearm X-ray as "Distal transverse radial fracture." The Nurses Note for R1, dated 6/6/22 at 9:05 pm, documents "Results from X-ray came back shows left arm and left hip fracture." (R1) sent to local hospital by ambulance. The Nurses Note for R1, dated 6/7/22 at 2:15 am, documents follow up entry as R1 being transferred from local hospital to another local hospital for surgical intervention. The PRN (as needed) MAR (medication administration record) for R1, dated 6/2/22 through 6/6/22 documents R1 received two Tylenol 500 mg (milligrams) tabs every morning

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		NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING:			E SURVEY
			IL6005631	B. WING			С
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_			MACOME	, IL 61455			
F	(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
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.002		pain assessment d	eneralized pain. There was no ocumented and no other pain ordered or administered during				
		Member stated she of the night on 6/2/2 were going to get so facility called again sending (R1) to the then the hospital did	am V10 (R1's) Family received a call in the middle 22 that R1 had fallen, and they ome X-rays then days later the telling V10 that they were hospital for a broken hip and if surgery yesterday (6/09/22). sn't know what took the facility rays.				
		was called to the face (local hospital). V18 facility and got report on 6/2/22 and the face (R1) had fractures to stated the facility had 6/3/22 and waited for showed Tylenol had stated "It was very of was broke and (R1) been obvious to the R1 moaned when shotstretcher. V18 stated	am, V18 Paramedic stated he cility to transport (R1) to the stated when he got to the the was told R1 had fallen cility X-rays on 6/6/22 said the hip and wrist. V18 did the order for the X-rays on ur days and R1's MAR only been given for pain. V18 bytious to me that her wrist was in pain. It should have facility as well." V18 stated the was moved onto the later that ited four days to get the				
	ii c	R1's Nurse on 6/2/22 called down to R1's r n the bathroom. R1 v complained about lef idn't have any visible to swelling or bruisin	pm, V13 LPN stated she was on night shift and was oom because R1 had fallen was lying on the floor and t arm and back pain. (R1) a signs of injury, there was g and (R1) was able to				

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED IL6005631 B. WING 06/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 WEST GRANT STREET** COUNTRYVIEW CARE CENTER-MACOMB MACOMB, IL 61455 SUMMARY STATEMENT OF DEFICIENCIES (X4)ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 5 S9999 to send R1 to the hospital because she was crying in pain but when she called V2 DON, V2 told her to notify the doctor and get X-rays in house. V13 stated she faxed V14 (R1's) PCP to notify of R1's fall and requested X-rays. V13 stated when she came into work on 6/3/22 night shift R1 was still complaining about pain. The second shift Nurse reported to (V13 LPN) that R1 was now complaining of left hip and foot pain and the second shift Nurse had called to get more X-rays. V13 LPN stated she did not work the weekend but when she came in to work on 6/6/22 the diagnostic service had been at the facility and she was waiting for the X-ray results. V13 stated the results came in sometime between 8:00 pm and 9:00 pm and R1 had a left hip and left wrist fracture. V13 stated V13 sent R1 to (local hospital) for treatment. On 6/10/22 at 3:36 pm, V16 CNA stated she was working on 6/2/22 when R1 fell and was called down to the B hall bathroom to help V17 CNA and V13 LPN. V16 stated R1 is supposed to use her walker but didn't and fell. V16 stated R1 was hysterical, anxious, and crying at first and was complaining about her left wrist and back hurting. "(R1) kept saying her wrist hurt." V16 stated R1's left wrist was a little red but didn't have any swelling and V13 LPN checked her and didn't feel anything out of the normal. V16 CNA stated after V13 LPN finished assessing R1 V16 CNA and V17 CNA assisted R1 up off the floor and V13 LPN pushed a wheelchair behind her because R1 wasn't able to stand. "(R1) kept saying it hurt and wouldn't bear weight so (R1) just sat in the wheelchair or in her recliner. V16 stated V3 LPN/ADON worked over the weekend as one of the Nurses and she reported to her that R1 couldn't bear weight and was in pain but does not know what was done.

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Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ANDPLANOF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED C IL6005631 B. WING 06/10/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 WEST GRANT STREET** COUNTRYVIEW CARE CENTER-MACOMB MACOMB, IL 61455 SUMMARY STATEMENT OF DEFICIENCIES (X4)(D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) S9999 Continued From page 6 S9999 On 6/10/22 at 9:18 am, V11 LPN stated she worked Thursday 6/2/22 from 6:00 am to 6:00 pm and was told in report that R1 had fallen and was complaining of pain and they were waiting for orders from V14 (R1's) PCP for X-rays. V11 stated she noticed a bump on R1's left forearm but nothing else and gave R1 Tylenol as per R1's usual request in the morning and that was all R1 received on 6/2/22 for pain. V11 stated she did call V14 (R1's) PCP (Primary Care Physician) prior to leaving her shift because R1 started complaining about foot and hip pain. V11 stated when she left that day she had not received an order back from V14. V11 LPN stated when she returned to work on 6/3/22 she found the orders for the X-rays had been received and she processed the orders and reported off to V5 Agency RN and told (V5) everything was done except calling (diagnostic service) to come and do the X-rays. V11 LPN stated she gave V5 Agency RN the 24 hour book that contained the (diagnostic service) phone number and reminded V5 Agency RN not to forget to call. On 6/9/22 at 1:40 pm, V5 Agency RN stated when she came into work on 6/2/22 at 10:00 am, V11 LPN had already processed the X-ray orders for R1 and had notified the (diagnostic service) to come and do the X-rays. V5 stated no one told her to call the diagnostic service to come and do the X-rays. V5 stated she did not call the (diagnostic service). On 6/10/22 at 4:12 pm, V3 LPN/ADON stated she did work the floor as a Nurse over the weekend and was (R1's) Nurse. V3 stated R1 was up in a wheelchair to the dining room for meals and fed herself. V3 stated she did not check for R1's X-ray results and stated "It didn't trigger in me to

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STATEME	Department of Public NT OF DEFICIENCIES					FORM	APPROVE	
AND PLAN OF CORRECTION		CIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DAT	ESURVEY	
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		MACOME	3, IL 61455	-				
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	check them because	e she hadn't complained of						
	any pain." v3 stated	She never saw R1's hody or						
	skin because R1 ha	d a sweater on and none of						
	the staff said anythir complaining or havir	ig to her about R1						
j	(6)			30				
	On 6/9/22 at 10:35 a	m V4 Agency RN stated she						
	Worked on 6/2/22 an	d 6/3/22 but was not R1's				0.		
	but on those two day	is usually up walking around						
1	wheelchair. V4 state	d when she returned to work						
}	on 6/6/22 R1 was sti	I Sitting in a wheelchair and				ļ		
	done. V4 stated she	rays for R1 had already been does not know how R1 was				12		
- }	able to sit up in a wh	eelchair with a left femur						
13	fracture and left wrist	fracture.	j			0		
J ,	On 6/9/22 at 1:48 nm	, V6 CNA stated before R1's					ı	
[1]	iali K1 could get up w	ith supervision and would	99			73		
- 11	use her walker to wal	k. but after R1 fell it would in the	9.					
	ake two to three of u or put her in her reclin	s to her up in a wheelchair				İ	j	
C	complain of a lot of pa	ain and finally out X-rays on					20	
6	6/6/22 and R1 was se	ent to the hospital.						
1	n 6/9/22 at 1:51 nm	V7 CNA ototo d vite	(a)				35	
0	ame into work on 6/2	V7 CNA stated when she 2/22 at 6:00 am, she was			*		DOM:	
10	old that R1 had fallen	during the night and was in l					>	
a	llot of pain. V7 stated	R1 complained of pain						
"	uning her shift and di	dn't want to stand up.						
0	n 6/9/22 at 1:56 pm,	V8 CNA stated she heard						
1 1	it complain of pain o	n 6/2/22 and (R1) was not					ı	
į w	alking anymore, and heelchair.	R1 was sitting in a		*			İ	
"		-						
0	n 6/9/22 at 2:15 pm,	V9 CNA stated she just						
j re	cently started workin	g at the facility but						
re l ar	members neiping ott nd R1 was complainii	ner CNA's to transfer R1						
Departme	nt of Public Health	g of pail.					1	

Illinois	Department of Public	Health				FOR	M APPROV	/EC
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(V2) DATE OUT			
IDENTIFICATION NUMBER		A. BUILDING:			(X3) DATE SURVEY COMPLETED			
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		IL6005631	B. WING_			06/10/2022		
NAMEOF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY	Y, STATE, ZIP CODE				_
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(X4)ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	CORRECTION		(X5)	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIA	ATE	DATE	E
S9999	Continued From page	ge 8	S9999					
	 On 6/9/22 at 12:00 :	m 1/2 DON /D:						
	Nursing) stated R1 f	om, V2 DON (Director of fell on 6/2/22 on third shift and						
	V13 LPN (Licensed	Practical Nurse) assessed						
	ner and R1 was con	iplaining of left forearm and						
Ì	stated V13 LPN noti	were no visible injuries. V2 fied V14 (R1's) PCP (Primary						
ľ	Care Physician's) an	Id requested X-ray orders 1/2			70			ŀ
1	stated later in the da	V R1 started complaining						
	(KTS) PCP and requ	in and V11 LPN notified V14 ested further X-rays. V2		. 157]	
	stated the diagnostic	Service the facility uses was		i ·				
1	supposed to be calle	d but wasn't. V2 stated V5						- [
· i	stated she found out	oosed to call but didn't. V2 on Monday 6/6/22 that the						ı
· ·	X-rays weren't done	for R1, and she had V11	0.6				,	1
	LPN call and have the	e diagnostic service come ated the X-rays showed					4	1
	fractures to R1's left	hip and left wrist and was				13		İ
[.]	sent to the (local hos	pital) for treatment.						J
·	On 6/10/22 at 11:21 a	ım 1/12 HD /U.m.s.s		·		ı		1
	Resources) Manager	for the diagnostic services	j			İ		1
- 1	ine racility uses stated	they received orders from						
	eft forearm, left foot	of R1's left hip with pelvis, and spine on 6/6/22 at 1:06				- 1		
	om, the X-rays were c	completed on 6/6/22 around						1
4	1:45 pm, and the resu	Its were faxed to the facility						
):i o/o/22 at 8:51 pm,):07 pm and results w	and called to the facility at vere verbally given to V13	}			1.		Т
	KN. V12 HR Manager	for diagnostic service	1			1		Г
S	tated they did not rec	eive any orders from the						Г
18	acility for R1 prior to 6	0/6/22.						
C	on 6/10/22 at 12:55 pt	m, V15 RN stated she is						
V	'14 (R1's) PCP Nurse	and V14 PCP received a						
S	omething in the morn	Thursday 6/2/22 at two ing that R1 had fallen and						
[W	as complaining of left	t forearm and back pain						
a	nd the facility request	ed X-rays. V15 stated later						

Ilinois Department of Public Health

	Department of Public				FORM	APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY		
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NAME OF	PROVIDER OR SUPPLIER		ET ADDRESS, CITY			1012022	
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	request for additional complaining of left had pm. V14 PCP gave X-rays. V15 RN state received the X-ray nashowing R1 had frace message back askir	m, V14 PCP received anotal X-rays because R1 starting and foot pain and at 5:0 the facility the order for the ded on Monday 6/6/22 we esults from the facility ctures and V14 PCP sent and for the cause of the taining X-rays and has still from the facility.	ted D7 e				
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