

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005631	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2024
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NAME OF PROVIDER OR SUPPLIER COUNTRYVIEW CARE CENTER-MACOMB	STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST GRANT STREET MACOMB, IL 61455
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(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	S 000		
S9999	<p>Complaint Investigation #2420296/IL168639</p> <p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.690 b)</p> <p>Section 300.690 Incidents and Accidents</p> <p>b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to report resident falls with injury to the State Agency for one of three residents (R1) reviewed for falls in the sample of three.</p> <p>Findings include:</p> <p>R1's Fall Report dated 12/8/23 at 3:00 p.m., documents R1 had a witnessed fall in the dining room that resulted in a laceration on the back of R1's head. R1's progress notes dated 12/8/23 at 6:20 p.m., document R1 was sent to the hospital and returned to the facility with a topical skin adhesive that closed R1's laceration to the back of the head.</p> <p>R1's Fall Report dated 12/19/23 at 3:15 p.m., documents R1 had a witnessed fall in front of the nurse's station that resulted in a laceration on the back of the head. R1's progress notes dated 12/19/23 at 4:50 p.m., documents R1 was sent to</p>	S9999		

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/12/24
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S9999	<p>Continued From page 1</p> <p>the hospital and returned to the facility with one staple to close R1's laceration to the back of the head.</p> <p>R1's Fall Report dated 1/22/24 at 4:25 p.m., documents R1 had a witnessed fall in the dining room that resulted in a laceration on the back of the head. R1's progress notes dated 1/22/24 at 7:30 p.m., documents R1 was sent to the hospital and returned with one staple to close R1's laceration to the back of the head.</p> <p>On 1/29/23 at 3:20 p.m., V1 (Administrator) stated the facility does not have a policy regarding notifying the State Agency of a serious incident. V1 stated the facility follows the state and federal regulations regarding reporting of a serious incident. V1 stated he has no evidence that the State Agency was notified of R1's serious incidents with physical injury on 12/8/23, 12/19/23 and 1/22/24 and they should have been notified.</p> <p>(C)</p>	S9999		