	-	ND HUMAN SERVICES MEDICAID SERVICES						1 APPROVEI 0. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	
		145596	B. WING				03/	11/2013
NAME OF PR			·		EET ADDRESS, CITY, STATE, ZIP CODE 00 EAST PARTRIDGE		-	
				М	ETAMORA, IL 61548			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000				
	Annual License and	Certification						
F 221 SS=D	Subpart U in Substar 483.13(a) RIGHT TO PHYSICAL RESTRA	BE FREE FROM	F	221				
	physical restraints im	right to be free from any posed for purposes of ence, and not required to edical symptoms.						
	by: Based on interview, review, the facility fai Physical Restraint Ma policy by providing a	Γ is not met as evidenced observation and record led to operationalize their anagement and Reduction medical symptom for the use of four residents (R2, R6, or physical restraints.						
	Findings include:							
	Reduction policy date individualized restrain be documented on th	estraint Management and ed 01/01/12 documents an nt reduction program must ne care plan with the type of use, circumstances under be used						
	03/01/13 through 03/	belt release belt and						
	-	aint Informed Consent dated a wheelchair with a seatbelt						
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	?F		TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/15/2013

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/15/2013 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION G	(X3) DATE	
		145596	B. WING	;		03/	11/2013
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE				1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	to be used for restles: activity/diversion and "as a therapeutic inter- not have an appropria documented. On 03/07/13 at 2:42 p Director of Nursing) c care plan does not do problem with a reduct E3 also confirmed that not document an app restraint use. On 03/07/13 at 1:50 p self in a wheelchair in locked unit. E11, LPN asked R22 to unfaste unable to complete the R2's Physician Order through 03/31/13 doc seatbelt." R2's Physical Restrait 01/28/13 documents, while in wheelchair to increased functioning On 03/07/13 at 8:07 at in the wheelchair at the common area of the f seatbelt was secured the table in front of R2 the seatbelt attemption On 03/07/13 at 1:45 p	sness and to provide an documents the reason used rvention." The consent does ate medical symptom o.m., E3, ADON (Assistant confirms that R22's current ocument R22's seatbelt as a tion plan and interventions. at the physician's order does ropriate symptom for o.m., R22 was propelling the hallway of the facility's N (Licensed Practical Nurse) in the seatbelt and R22 was his task. Sheet dated 03/01/13 cuments, "self releasing nt Informed Consent dated "self release seat belt used o provide an opportunity for " a.m., R2 was sitting upright the breakfast table in the facility's locked unit. R2's . Breakfast was sitting on 2. R2 was looking down at	F	- 22	21		

Facility ID: IL6011464

If continuation sheet Page 2 of 21

STATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY
and plan of	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	CON	IPLETED
		145596	B. WING		0;	3/11/2013
NAME OF PF	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	answered, "No. I don "We (facility staff) kee (R2) is at the breakfa forward so much." E	e 2 when asked and E12 't think so." E11 also stated, ep R2's belt fastened while st table because (R2) leans 11 then confirms that R2's vent the resident from	F 22	1		
	through 03/31/13 doc laptop cushion as new restlessness but give	Sheet dated 03/01/13 suments wheelchair with eded for agitation or extreme s no indication of a medical ne use of the restraint.				
	wheelchair near the r common area of the f laptop cushion in place staff members were p R6 was calm in appe E13, LPN stated that that R6 had been give (anti-anxiety medicati to get R6 to fold laur put (R6) in the wheel	acility's locked unit with a ce. Several residents and present in this same area. arance and readily smiled. R6 was getting agitated and				
-	that R6, "shouldn't ha nurse's station if the i is what agitated her. (laptop cushion) whe combative."	o.m., E3, ADON confirms two been restrained at the ncreased amount of people We (facility staff) use it n (R6) is confused and				
F 225 SS=D	483.13(c)(1)(ii)-(iii), (INVESTIGATE/REPC ALLEGATIONS/INDI	DRT	F 22	5		

Facility ID: IL6011464

If continuation sheet Page 3 of 21

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 03/15/2013 1 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		PLE CONSTRUCTION		(X3) DATE	
		145596	B. WING				03/	11/2013
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SNYDER	VILLAGE				1200 EAST PARTRIDGE METAMORA, IL 61548			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	٦IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 225	been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misap and report any knowle court of law against a indicate unfitness for other facility staff to th or licensing authoritie The facility must ensu- involving mistreatmer including injuries of u misappropriation of re- immediately to the ad to other officials in ac through established p State survey and cert The facility must have violations are thoroug prevent further potent investigation is in pro- The results of all inve- to the administrator o representative and to with State law (includ certification agency) v incident, and if the all appropriate corrective	employ individuals who have abusing, neglecting, or by a court of law; or have into the State nurse aide ouse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s. ure that all alleged violations nt, neglect, or abuse, nknown source and esident property are reported ministrator of the facility and cordance with State law procedures (including to the ification agency). e evidence that all alleged why investigated, and must tial abuse while the gress.	F	22				

If continuation sheet Page 4 of 21

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	TE SURVEY
and plan of	FCORRECTION	IDENTIFICATION NUMBER:	• •	NG	CO	MPLETED
		145596	B. WING		0	3/11/2013
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	Based on interview a failed to immediately to the administrator for allegations reviewed. Findings include: The Facility's staff rep documents R34 repo abuse. The facility's I Allegation form docum was notified of the all	and record review the facility report allegations of abuse or two of three abuse port form dated 7/8/12 rted an allegation of physical nitial 24 Hour Abuse/Neglect ments E1 (Administrator) egation on 7/9/12 at 8:00 ras not reported to the	F2	225		
F 279 SS=D	2/17/13 at 10:30AM, allegation of abuse to Abuse/Neglect Allega the initial report date was initiated by E1. T reported to the Admir On 3/7/13 E1 acknow Allegations on 7/8/12 reported immediately documentation. 483.20(d), 483.20(k)(COMPREHENSIVE (A facility must use the to develop, review an comprehensive plan The facility must deve plan for each residen	Vledged the Abuse and 2/18/13 were not to E1 according to the 1) DEVELOP CARE PLANS e results of the assessment of revise the resident's	F2	279		

Facility ID: IL6011464

If continuation sheet Page 5 of 21

FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(,	Y
	IDENTIFICATION NUMBER.	A. BUILDI	NG			GOINFLETED	
	145596	B. WING				03/11/201	13
OVIDER OR SUPPLIER					IP CODE		
ILLAGE							
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	(EACH CORRECTIN CROSS-REFERENCE	/E ACTION SHOULD BE D TO THE APPROPRIAT	COMP	(X5) PLETION DATE
medical, nursing, and needs that are identifi assessment. The care plan must do to be furnished to atta highest practicable ph psychosocial well-bein §483.25; and any serr be required under §48 due to the resident's e §483.10, including the	mental and psychosocial ed in the comprehensive escribe the services that are in or maintain the resident's hysical, mental, and ng as required under vices that would otherwise 33.25 but are not provided exercise of rights under	F	279				
by: Based on interview, or review, the facility fail isolation for one resid plan restraint use for t sampled for care plan Findings include: 1. The care plan for F identifies Ecoli in the does not include any isolation initiated or in approaches related to E3 (Assistant Director 03/07/2013 at 02:04 F	observation, and record ed to care plan contact ent (R14) and failed to care two residents (R2 and R6) is in the sample of 19. R14 dated 02/18/2013 urine. This same care plan reference to the contact terventions, goals or o these needs.						
	CORRECTION DVIDER OR SUPPLIER ILLAGE SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR L Continued From page medical, nursing, and needs that are identifi assessment. The care plan must du to be furnished to atta highest practicable ph psychosocial well-bein §483.25; and any serr be required under §48 due to the resident's of §483.10, including the under §483.10(b)(4). This REQUIREMENT by: Based on interview, of review, the facility fail- isolation for one resid plan restraint use for f sampled for care plan Findings include: 1. The care plan for F identifies Ecoli in the plan column of the plan for F identifies Ecoli in the plan findings include any plan solation initiated or in approaches related to E3 (Assistant Director 03/07/2013 at 02:04 F entry regarding contai	CORRECTION IDENTIFICATION NUMBER: 145596 DVIDER OR SUPPLIER ILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to care plan contact isolation for one resident (R14) and failed to care plan restraint use for two residents (R2 and R6) sampled for care plans in the sample of 19.	CORRECTION IDENTIFICATION NUMBER: A. BUILDI 145596 B. WING DVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 5 ID medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. F : The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to care plan contact isolation for one resident (R14) and failed to care plan restraint use for two residents (R2 and R6) sampled for care plans in the sample of 19. Findings include: 1. The care plan for R14 dated 02/18/2013 identifies Ecoli in the urine. This same care plan does not include any reference to the contact isolation initiated or interventions, goals or approaches related to these needs. E3 (Assistant Director of Nursing) stated 03/07/2013 at 02:04 PM '' would expect to see an entry regarding contact isolation on the care	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 145596 B. WING ILLAGE STREET A ILLAGE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 5 F 279 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. F 279 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to care plan contact isolation for one resident (R14) and failed to care plan restraint use for two residents (R2 and R6) sampled for care plans in the sample of 19. Findings include: 1. The care plan for R14 dated 02/18/2013 identifies Ecoli in the urine. This same care plan does not include any reference to the contact isolation inluited or interventions, goals or approaches related to these needs. E3 (Assistant Director of Nursing) stated 03/07/2013 at 02:04 PM "I would expect to see an entry regarding contact isolation on the care	CORRECTION IDENTIFICATION NUMBER: A BUILDING 145596 B. WING VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, Z ILLAGE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDENT CROSS-REFERENCE DEF PREVIDENT CROSS-REFERENCE DEF Continued From page 5 F 279 Medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. F 279 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25 but are not provided due to the resident'S exercise of rights under \$483.10 (b)(4). F This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to care plan contact isolation for one resident (R14) and failed to care plan restraint use for two residents (R2 and R6) sampl	IDENTIFICATION NUMBER: A BUILDING 145596 B. WING DVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE ILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) D PRETIX CACH CORRECTIVE ACTION NUMBER: D PRETIX PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) F 279 Continued From page 5 D PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION NUMBER: PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION NUMBER: Continued From page 5 D PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION NUMBER: PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION NUMBER: Continued From page 5 D PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION NUMBER: PROVDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION NUMBER: The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of nghts under §483.10(b)(4). F 279 This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the facility failed to care plan contact isolation for o	COMPLETED IDENTIFICATION NUMBER A BUILDING COMPLETED 145596 B. WING 03/11/20 NUDER OR SUPPLIER STREET ADDRESS, OTTY, STATE, 2P CODE 03/11/20 ILLAGE STREET ADDRESS, OTTY, STATE, 2P CODE 00/11/20 COMPLETED Into Example of the state of the sta

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING			IFLETED
		145596	B. WING		0:	8/11/2013
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	top cushion as needer restlessness. Removing On 03/06/13 at 4:10 p wheelchair with a lap the facility's locked up R6's current care plan indicate the wheelcha problem with goals an On 03/07/13 at 2:42 p reference to the wheel is documented on R6	ed for agitation, extreme ve every two hours." o.m., R6 was sitting in a top cushion in place near nit's nurse's station. n was reviewed and did not air with lap top cushion as a nd interventions. o.m., E3 confirms that no elchair with lap top cushion i's current care plan. der Sheet dated 03/01/13 cuments, "reclining removed as needed-	F 279			
F 280 SS=E	indicate the reclining cushion or the self re problem with goals at On 03/07/13 at 2:42 p reclining wheelchair we problem on R2's curr 483.20(d)(3), 483.10(PARTICIPATE PLAN) The resident has the incompetent or other incapacitated under t	nd interventions. b.m., E3 confirms that the with tray and the self ire not identified as a ent care plan. (k)(2) RIGHT TO NING CARE-REVISE CP right, unless adjudged wise found to be he laws of the State, to g care and treatment or	F 280	5		

Facility ID: IL6011464

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/15/2013 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		LE CONSTRUCTION	(X3) DATE	
		145596	B. WING			03/	11/2013
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER \	/ILLAGE				1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	27	F	280	0		
	within 7 days after the comprehensive asses interdisciplinary team physician, a registere for the resident, and o disciplines as determinand, to the extent pra the resident, the resid- legal representative; a	e plan must be developed e completion of the ssment; prepared by an , that includes the attending d nurse with responsibility other appropriate staff in ined by the resident's needs, cticable, the participation of dent's family or the resident's and periodically reviewed n of qualified persons after					
	by: Based on observation interview, the facility f interventions after fall (R2, R6, R7, R11, R1 reviewed for care plan Findings include: 1. Facility Fall Risk Pr Policy dated Septemb to implement resident prevent further occurr on the care plan and resident's care guide. R18's Fall Risk Assess 12/27/12 document R On 03/05/13 at 9:13 at	Failed to care plan new is for eight of 19 residents 2, R18, R20, and R22) ns in the sample of 19. revention and Monitoring per 2007 documents for staff t specific interventions to rences, care plan the event add interventions to the					

If continuation sheet Page 8 of 21

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		145596	B. WING _	4G		0/44/0040
NAME OF PI	ROVIDER OR SUPPLIER	140000		STREET ADDRESS, CITY, STATE, ZIP CODE	0	3/11/2013
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 280	Velcro knee immobiliz right knee. E3, ADON Nursing) stated, "(R14 Incident Reports docu and 03/01/13. No into were documented on dated 12/12/12. R18's current care pla documents, "Residen no new approaches d On 03/07/13 at 8:15 a wheelchair in the facil area. R18 had a large face and R18 was rep which had a Velcro kr place. On 03/07/13 at 10:28 that R18's care plan f R18 fell on 12/22/12 a "They (new approach been on the care plan 2. R6's Fall Risk Asse and 12/20/12 docume On 03/05/13 at 1:31 p table in the facility's s E9, CNA (Certified Nu laundry in front of R6. laundry. Facility Incident Repo	zer secured in place on her N (Assistant Director of 8) fell last night. Facility's ument R18 fell on 12/22/12 erventions for these falls R18 ' s current care plan an dated 12/12/12 it is at risk for falls," and has locumented since 12/12/12. a.m., R18 was sitting in a lity's secured unit's common e amount of bruising to the positioning R18's right leg nee immobilizer fastened in a.m., E3, ADON confirmed had not been updated after and 03/01/13 and stated, use for R18) should have n." essments dated 09/04/12 ent R6 is at high risk for falls. o.m., R6 was sitting at a ecured unit's common area. urse's Aide) sat a basket of . R6 began folding the orts document R6 fell on 1/26/13, and 02/15/13. No e falls were documented on	F2			

Facility ID: IL6011464

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/15/2013 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		145596	B. WING			03/	11/2013
NAME OF PR	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	/ILLAGE				1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page	9	F	28	0		
	that R6's care plan ha R6 fell on 10/06/12, 1	a.m., E3, ADON confirmed ad not been updated after 1/20/12, 01/26/13, and "They (new approaches for n on the care plan."					
		essments dated 09/12/12, 3 document R22 is at high					
	wheelchair with a sea	o.m., R22 was sitting in a tbelt fastened propelling ne facility's locked unit.					
	10/14/12, 01/04/13, a	e falls were documented on					
	that R22's care plan h R22 fell on 10/14/12,	a.m., E3, ADON confirmed ad not been updated after 01/04/13, and 01/05/13 and pproaches for R22) should e plan. "					
		essments dated 04/25/12, nd 01/10/13 document R2 is					
	wheelchair in the com locked unit. R2 had a	n.m., R2 was sitting in a mon area of the facility's a seatbelt secured with a e. R2 was attempting to					
		rts document R2 fell on 9/11/12, 10/18/12, 10/29/12,					

Facility ID: IL6011464

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ___ 145596 B. WING 03/11/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1200 EAST PARTRIDGE SNYDER VILLAGE METAMORA, IL 61548 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 10 F 280 11/07/12, and 03/02/13. No interventions for these falls were documented on R2's current care plan dated 10/25/12. On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R2's care plan had not been updated after R2 fell on 05/24/12, 06/21/12, 09/11/12, 10/18/12, 10/29/12, 11/07/12, and 03/02/13 and stated, "They (new approaches for R2) should have been on the care plan." 5. R7's Fall Risk Assessments dated 04/17/12. 08/12/12, 11/01/12, and 01/05/13 document R7 is at high risk for falls. On 03/05/13 at 1:40 p.m., R7 was ambulating with a walker in the hallway of the facility's locked unit and sat down in a chair of the common area. Facility Incident Reports document R7 fell on 06/20/12 and 09/12/12. No interventions for these falls were documented on R7's care plan dated 05/09/12. On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R7's care plan had not been updated after R7 fell on 06/20/12 and 09/12/12 and stated, "They (new approaches for R7) should have been on the care plan." 6. A facility fall investigation form dated 5-12-12 and 9-15-12 documents that R11 fell on those dates. R11's fall prevention care plan dated 12-06-11 does not include fall prevention measures initiated for those dates, nor does it include the evaluation of the effectiveness of previous fall prevention measures.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 03/15/2013

STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	IO. 0938-039 E SURVEY
ND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COM	IPLETED
		145596	B. WING		0	3/11/2013
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 280 F 281 SS=D	 7. A facility fall investigation of the services provides for the services provide must meet profession 	tigation form dated 6-04-12 nts that R12 fell on those vention care plan dated lude fall prevention r those dates, nor does it n of the effectiveness of on measures. ent forms dated 3/3/13, boument R20 had falls. R20's n documented at risk for assessment dated are plan did not document nterventions for the falls on 12. .m. E3 verified the the should be on the Care Plan. ex Pre Prevention and ted September 2007 anning the event on the care eventions to the resident's PICES PROVIDED MEET ANDARDS d or arranged by the facility nal standards of quality. F is not met as evidenced on, interview, and record	F 2 F 2			

Facility ID: IL6011464

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STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	IO. 0938-039
AND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G		MPLETED
		145596	B. WING		0	3/11/2013
NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 281	medications to reside glucose monitoring to syringe of insulin, dra into the syringe based sheet (POS). E4 did verify the dose of insu- for R17, nor did she verify the dose of insu- for R17, nor did she verify the dose of insu- type of insulin she was correct based on R17 administer the insulin performed blood gluco prepared a syringe of an amount of insulin in R27 's physician 's of did not ask another n insulin in the syringe she verify with another she was administerin on R27 's POS. 2. On 3-05-13 at 11:2 Practical Nurse) was residents. E4 perform monitoring to R28 the insulin, drawing up an syringe based on R28 (POS). E5 stated that s insulin that she need drawn up the correct by doing a " double of E5 took the syringe fue bottle to E4 (Licensed could verify E5 was for orders correctly. E5 sa	nple. 1:05 E4 was passing ints. E4 performed blood 0 R17 then prepared a awing up an amount of insulin d on the physician 's order not ask another nurse to ulin in the syringe intended verify with another nurse the as administering to R17 was 7's POS. E4 proceeded to to R17. At 11:10a.m. E4 iose monitoring to R27. E4 f insulin for R27, drawing up into the syringe based on order sheet (POS). Again E4 urse to verify the dose of intended for R27, nor did er nurse the type of insulin g to R27 was correct based 20a.m. E5 (Licensed passing medications to	F 28	81		

Facility ID: IL6011464

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STATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION NG	(X3) DA	<u>NO. 0938-039</u> TE SURVEY MPLETED
		145596	B. WING		0	3/11/2013
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 EAST PARTRIDGE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 281 F 323 SS=D	verify the dosage or t R28 's physician 's of A facility policy on me dated 1-01-11 docum must be verified with syringe and insulin bo administration." On 3-06-13 at 11:00a stated that the new ir implemented 1/2013 administration errors that all nursing staff v the new insulin policy facility medication ad A staff development i 1-15-13 to 1-17-13 do (Licensed Practical N service on insulin adu return demonstration A document titled clir practice manual from Connecticut Health C 9/2012 documents the insulin requires dosage prior to administration errors. 483.25(h) FREE OF J HAZARDS/SUPERVI The facility must ensi- environment remains as is possible; and ea	ype of insulin by looking at order sheet. edication administration hents that, "All insulin orders another nurse including ottle prior (to) a.m. E2 (Director of Nurses) hsulin policy was to prevent insulin from occurring. E2 stated vere given and in service on which was added to the ministration policy. n service record dated occuments that E4 and E5 lurses) attended the in ministration which included a by nursing staff. hical procedure nursing the University of center dated as revised at a high risk medication like ge verification by two nurses in to prevent medication ACCIDENT ISION/DEVICES ure that the resident as free of accident hazards		281		

Facility ID: IL6011464

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	ISTRUCTION		(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			COMP	LETED
		145596	B. WING				03/ [,]	11/2013
NAME OF PR	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE,	ZIP CODE		
SNYDER	/ILLAGE				EAST PARTRIDGE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETIO DATE
F 323	This REQUIREMENT by: Based on observatio review the facility faile interventions after fall	is not met as evidenced	F	323				
	dated September 200 implement resident sp prevent further occurr	vention and Monitoring Policy 07 documents for staff to becific interventions to rences, care plan the event add interventions to the						
		esments dated 12/12/12 and 18 is at high risk for falls.						
	with dark purple facia to the chin and a velc in place on the right k	a.m., R18 was resting in bed I bruising from the forehead ro knee immobilizer secured mee. E3, ADON (Assistant tated, "(R18) fell last night."						
	12/22/12 and 03/01/1	ports document R18 fell on 3. No interventions for mented on R18's current 2/12.						
		an dated 12/12/12 t is at risk for falls," and has locumented since 12/12/12.						
		a.m., R18 was sitting in a lity's secured unit's common						

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STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG		COMPLETED	
		145596	B. WING		0	3/11/2013	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
SNYDER	VILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 323	area. R18 had a large face and R18 was rey which had a velcro kr place. On 03/07/13 at 10:28 that R18's care plan h R18 fell on 12/22/12 a "They (new approach been on the care plan R6's Fall Risk Assess 12/20/12 document R On 03/05/13 at 1:31 p table in the facility's s E9, CNA (Certified Ne laundry in front of R6 laundry. Facility Incident Repo 10/06/12, 11/20/12, 0 interventions for thes R6's current care plan On 03/07/13 at 10:28 that R6's care plan ha R6 fell on 10/06/12, 1 02/15/13 and stated, R6) should have been R22's Fall Risk Assess 12/06/12, and 02/27/ risk for falls.	e amount of bruising to the positioning the right leg nee immobilizer fastened in a.m., E3, ADON confirmed had not been updated after and 03/01/13 and stated, les for R18) should have n." sments dated 09/04/12 and 86 is at high risk for falls. o.m., R6 was sitting at a becured unit's common area. urse's Aide) sat a basket of . R6 began folding the orts document R6 fell on 11/26/13, and 02/15/13. No e falls were documented on n dated 09/04/12. a.m., E3, ADON confirmed ad not been updated after 11/20/12, 01/26/13, and "They (new approaches for n on the care plan." assments dated 09/12/12, 13 document R22 is at high o.m., R22 was sitting in a	F	323			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/15/2013 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		145596	B. WING			03/	11/2013
NAME OF PR	OVIDER OR SUPPLIER			ST	STREET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	/ILLAGE				1200 EAST PARTRIDGE METAMORA, IL 61548		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	9 16	F	32	23		
	Facility Incident Report 10/14/12, 01/04/13, a interventions for these R22's current care plat On 03/07/13 at 10:28 that R22's care plan h R22 fell on 10/14/12, stated, "They (new a have been on the care R2's Fall Risk Assess 07/25/12, 10/25/12, a at high risk for falls. On 03/07/13 at 8:07 a wheelchair in the corr locked unit. R2 had a seatbelt alarm in plac remove the seatbelt. Facility Incident Repo 05/24/12, 06/21/12, 0 11/07/12, and 03/02/1 these falls were documplan dated 10/25/12. On 03/07/13 at 10:28 that R2's care plan ha R2 fell on 05/24/12, 0	rts document R22 fell on nd 01/05/13. No e falls were documented on an dated 10/11/12. a.m., E3, ADON confirmed nad not been updated after 01/04/13, and 01/05/13 and pproaches for R22) should					
	on the care plan." R7's Fall Risk Assess	es for R2) should have been ments dated 04/17/12, nd 01/05/13 document R7 is					

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DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY
CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	IPLETED
	145596	B. WING		O	3/11/2013
VIDER OR SUPPLIER			, , ,		
LLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
Continued From page	17	F 3	23		
with a walker in the ha unit and sat down in a Facility Incident Repo 06/20/12 and 09/12/12 these falls were docur dated 05/09/12. On 03/07/13 at 10:28 that R7's care plan ha R7 fell on 06/20/12 ar "They (new approache on the care plan." 483.65 INFECTION C SPREAD, LINENS The facility must estat Infection Control Prog safe, sanitary and con to help prevent the de of disease and infection (a) Infection Control P The facility must estat Program under which (1) Investigates, contr in the facility; (2) Decides what proc should be applied to a (3) Maintains a record actions related to infer (b) Preventing Spread	allway of the facility's locked chair of the common area. rts document R7 fell on 2. No interventions for mented on R7 's care plan a.m., E3, ADON confirmed d not been updated after id 09/12/12 and stated, es for R7) should have been ONTROL, PREVENT blish and maintain an ram designed to provide a mfortable environment and velopment and transmission on. rogram blish an Infection Control it - ols, and prevents infections redures, such as isolation, in individual resident; and of incidents and corrective ctions.	F 4	41		
	VIDER OR SUPPLIER LLAGE SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page On 03/05/13 at 1:40 p with a walker in the ha unit and sat down in a Facility Incident Repoi 06/20/12 and 09/12/12 these falls were docur dated 05/09/12. On 03/07/13 at 10:28 that R7's care plan ha R7 fell on 06/20/12 an 'They (new approache on the care plan." 483.65 INFECTION C SPREAD, LINENS The facility must estat Infection Control Prog safe, sanitary and cont to help prevent the de of disease and infection (a) Infection Control Prog safe, sanitary and cont to help prevent the de of disease and infection (a) Infection Control Prog safe, sanitary and cont to help prevent the de of disease and infection (a) Infection Control Prog safe, sanitary and cont to help prevent the de of disease and infection (a) Infection Control Prog safe, sanitary and cont to help prevent the de of disease and infection (a) Infection Control Prog safe, sanitary and cont to help prevent the de of disease and infection (b) Preventing Spread (c) Preventing (145596 VIDER OR SUPPLIER LLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 On 03/05/13 at 1:40 p.m., R7 was ambulating with a walker in the hallway of the facility's locked unit and sat down in a chair of the common area. Facility Incident Reports document R7 fell on 06/20/12 and 09/12/12. No interventions for these falls were documented on R7 's care plan dated 05/09/12. On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R7's care plan had not been updated after R7 fell on 06/20/12 and 09/12/12 and stated, 'They (new approaches for R7) should have been on the care plan." 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	145596 B. WING VIDER OR SUPPLIER ID LLAGE ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 17 F 3 On 03/05/13 at 1:40 p.m., R7 was ambulating with a walker in the hallway of the facility's locked unit and sat down in a chair of the common area. Facility Incident Reports document R7 fell on 06/20/12 and 09/12/12. No interventions for these falls were documented on R7 's care plan dated 05/09/12. On 03/07/13 at 10:28 a.m., E3, ADON confirmed that R7's care plan had not been updated after R7 fell on 06/20/12 and 09/12/12 and stated, 'They (new approaches for R7) should have been on the care plan." F4 A33.65 INFECTION CONTROL, PREVENT SPREAD, LINENS F4 The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. F4 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infection (1) When the Infection Control Program determines that a resident needs isolation to	Idesse B. WING LLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 1200 EAST PARTRIDGE BTREET ADDRESS, CITY, STATE, ZIP CODE I200 EAST PARTRIDGE BETAMORA, IL 61548 SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORE (EACH DEFIDICION WIST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREEN TAG PROVIDERS PLAN OF CORE Continued From page 17 F 323 F 323 On 03/05/13 at 1:40 p.m., R7 was ambulating with a walker in the hallway of the facility's locked unit and sat down in a chair of the common area. F 323 Facility Incident Reports document R7 fell on 09/20/12 and 09/12/12. No interventions for these falls were documented on R7 's care plan dated 05/09/12. F 441 On 03/05/13 at 10:28 a.m., E3, ADON confirmed that R7's care plan had not been updated after R7 fell on 06/20/12 and 09/12/12 and stated, They (new approaches for R7) should have been on the care plan. F 441 SPREAD, LINENS F 441 SPREAD, LINENS F 441 SPREAD, LINENS F 441 Self.esinitary and comfortable environment and to help prevent the development and transmission of disease and infection. F 441 (a) Infection Control Program The facility must estabilish an Infection Control Program under which it - 11 Investigates, controls, and prevents infections in the facility: (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.<	Image:

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CENTER	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	со	MPLETED	
		145596	B. WING		0	3/11/2013
NAME OF PF	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
SNYDER	VILLAGE			00 EAST PARTRIDGE ETAMORA, IL 61548		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 441	communicable diseas from direct contact wil direct contact will trar (3) The facility must r hands after each dire hand washing is indic professional practice. (c) Linens Personnel must hand transport linens so as infection.	erohibit employees with a se or infected skin lesions th residents or their food, if asmit the disease. equire staff to wash their ct resident contact for which sated by accepted le, store, process and to prevent the spread of	F 441			
	 by: A. Based on observice with the facility faile hand hygiene during medication administration (R17, R19) reviewed sample of 19, and two the supplemental sam Findings include: 1. On 3-05-13 at 11 Practical Nurse) was residents. E4 prepare R17 then administere upper arm without ap the injection. 2. On 3-05-13 at 11 syringe of insulin for Finding Single of Single Single	ation for two of 19 residents for infection control in a o residents (R27, R28) on				

			0/02 10/12		0.00		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	· · · ·	(X3) DATE SURVEY COMPLETED	
		145596	B. WING		c	3/11/2013	
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SNYDER	/ILLAGE			1200 EAST PARTRIDGE METAMORA, IL 61548			
		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	(X5) COMPLETIO DATE	
F 441	Continued From page	e 19	F 4	41			
		oviding incontinence care to					
		9 to turn to the right while E8					
	cleaned fecal material from R19 's buttocks and perineal area. Once E8 finished with R19 's						
	incontinence care, E8	3 then assisted R19 to					
	reposition in bed, touching R19's bare skin on						
		clothing. E8 then applied a					
		19. E8 did not remove her					
	4	touching R19 or touching					
	R19 's clothing and li						
		administration policy dated nat staff should, " Use					
		s as needed when giving					
		cility policy for subcutaneous					
		ections) dated as revised					
		hat staff should, " put on					
	gloves, " prior to givi	ng an injection to a resident.					
		m. E6 (Licensed Practical					
	Nurse/Infection Control Coordinator) stated that, " Nurses should wear gloves to give injections and wash their hands after removed E6 stated that all						
	nursing had attended	0					
	demonstrations of ins	cluded staff giving return					
		-					
		A staff development in service record dated 1-15-13 to 1-17-13 documents that E4 (Licensed					
		nded the in service which					
	included a return den injections.						
		vation, interview, and record					
	review the facility failed to follow their policy for						
	disinfecting shared bl	ood glucose monitoring					
	equipment for one of						
	-	ucose monitoring on a					
	-	e resident (R29) on the					
	supplemental sample						
	Findings include:						
	On 2 OF 12 at 11.05-	.m. E4 (Licensed Practical					

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STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRU		(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		145596	B. WING			03/11/2013	
NAME OF PF	OVIDER OR SUPPLIER			1200 EAST	ESS, CITY, STATE, ZIP CODE PARTRIDGE (A, IL 61548		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 441	Nurse)performed bloc R17 by puncturing the a sharp lancet and ag inserted into the bloo machine. After E4 fir entered R27 ' s room blood glucose monitoring m disinfecting that mach R27. After E4 finishe glucose, she then ret monitoring machine t medicine cart without machine. A facility policy for cle glucose monitoring m 1-07-13 documents th cleaned after every u resident. " On 3-06-13 at 3:40p.	od glucose monitoring to e end of R17 ' s finger using oplying blood to a test strip d glucose monitoring hished with R17 she then and performed the same bring, using the same blood hachine, and without hine before reusing it on ed monitoring R27 ' s blood turned the blood glucose to a drawer in E4 ' s t using disinfectant on the eaning glucometers (blood hachine) dated as revised hat, " All glucometers will be use and in between each m. E6 (Licensed Practical trol Coordinator) stated that he glucometer down	F	141			

Facility ID: IL6011464

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