STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011464	A. BUILDING: _____ B. WING _____	02/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SNYDER VILLAGE	1200 EAST PARTRIDGE METAMORA, IL 61548

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S 000	Initial Comments Annual Licensure & Recertification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)6) 300.1220 b)3) 300.3240 a) 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 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. Section 300.1220 Supervision of Nursing	S9999	Attachment A Statement of Licensure Violations	

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Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These regulations are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to re-evaluate fall interventions, implement fall interventions, and ensure staff were aware of resident specific fall interventions for one of seven residents (R72) reviewed for falls in the sample of 40. These failures resulted in R72 falling on two separate occasions and sustaining an eyebrow laceration, closed head injury, and a left hip fracture.

Findings include:

The facility's Falls Clinical Protocol Assessment, Cause, and Intervention policy, dated 2-2-18, documents, "The need for changes in

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interventions will be assessed and changed as need by the medical doctor, nursing personnel, or interdisciplinary team. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling."

R72's Admission Physician Orders, dated 11-1-19 through 11-30-19, document R72 has diagnoses of Unsteady Gait, Falling, and Dementia.

R72's Admission Minimum Data Set (MDS) Assessment, dated 11-20-19, documents R72 is severely cognitively impaired, and R72 requires extensive assistance of one person physical assistance for bed mobility, transfers, walking, and toilet use.

R72's Physician Progress Note, dated 11-12-19 (Date of Admission) and signed by V3 (R72's Physician), documents, "(R72) living at assisted living past few years. Over past few weeks, more confusion, unable to find room, not recognizing family, and requires higher level of care. Moved to skilled nursing facility."

R72's Event Report, dated 11-15-19 (three days after admission to facility), documents, "(R72) in recliner and tried to stand unassisted. (R72) was found on bottom with feet in front of her. No visible injuries. Care Plan Intervention: 15 minute checks x 72 hours."

R72's Event Report, dated 11-29-19, documents, "(R72) on floor in front of recliner and laying on right side. (R72) pointed to head when asked where her pain was. Laceration noted above right eyebrow. Pressure applied above right eyebrow. Sent to hospital emergency room via ambulance. Care Plan Intervention: Encourage

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(R72) to utilize seating in common areas versus sitting in her room alone."

R72's Fall Investigation and Summary, dated 11-29-19 and signed by V9 (ADON/Assistant Director of Nursing), documents, "(R72) was found on the floor in front of her recliner laying on her right side. Laceration above right eyebrow with active bleeding. Body alarm has been put into place."

R72's Emergency Room Note, dated 11-29-19, documents, "Primary Impression: closed head injury. Additional Impressions: Fall-laceration above right eye three centimeters in length. Closed laceration with five sutures."

R72's Event Report, dated 12-16-19 and signed by V7 (RN/Registered Nurse), documents, "Description: Fall. Pain Observation: Severe pain to the left hip. (R72) got to the bathroom without assist. (V8/Housekeeper) saw (R72) by bathroom door and then (R72) fell to the floor. V9 (Assistant Director of Nursing/ADON) present and aware. Fall prevention plan interventions completed: Educate resident, hi-low bed, gripper socks, and encourage (R72) to remain in common areas when sitting in her room alone."

R72's Event Report Section Fall Prevention Plan Interventions Completed, dated 12-16-19, documents R72 did not have a body alarm on at the time of the fall on 12-16-19.

R72's Radiology Report, dated 12-16-19, documents, "Impression: Acute mildly displaced fracture left femoral neck (left hip)."

R72's Fall Care Plan documents the following fall intervention dated 11-15-19: 15 minute checks

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times 72 hours. The same care plan does not include any other fall intervention after the 15 minute checks were completed (11-18-19) and before the fall on 11-29-19 resulting in a closed head injury and right eyebrow laceration.

R72's Fall Investigation and Clinical Record does not include documentation of a re-evaluation of R72's fall interventions after R72's 15 minutes checks were completed on 11-18-19.

R72's Fall Care Plan documents the following fall interventions dated 11-29-19: Place body alarm on R72 to alert staff of attempt to transfer. Encourage R72 to utilize seating in common areas versus sitting in her room. This same Fall Care Plan documents R72's body alarm was discontinued by an unknown staff member on the same day implemented (11-29-19).

R72's Clinical Record does not include documentation of re-evaluation of R72's fall interventions or the reason for discontinuation of R72's body alarm after 11-29-19.

On 2/02/20 at 9:15 AM, and 02/05/20 at 9:05 AM, R72 was in her room, alone, sitting in her recliner.

On 2/03/20 at 2:21 PM, V8 (Housekeeper) stated, "On 12-16-19 I was across the hallway from (R72). I looked into (R72's) room and saw (R72) fall to the floor in front of the bathroom door. I immediately got a nurse and CNA (Certified Nursing Assistant). I do not remember who the nurse and CNA were. I do not remember an alarm sounding."

On 2/04/20 at 12:00 PM, V7 (Registered Nurse) stated, "On 12-16-19 (V8) saw (R72) lying on the

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floor in the doorway of her bedroom. (V8) immediately summoned me. When I assessed (R72) she was complaining of pain to the left hip. I sent (R72) to the emergency room. (R72) did not have a body alarm on when she fell. (R72) had gotten up out of bed and tried to walk to the bathroom by herself."

On 2/04/20 at 12:15 PM , V2 (Director of Nursing) stated, "When (R72) fell on 11-15-19 we (facility staff) decided to do 15 minute checks for 72 hours to determine (R72's) baseline and how (R72) was going to adjust to the facility. The facility only did 15 minute checks for 72 hours after (R72's) fall and we did not reassess (R72's) fall interventions after the 72 hours. We should have re-evaluated (R72's) fall interventions. (R72) did not have any other fall interventions implemented after the 11-15-19 fall. On 11-29-19 (R72) was found on the floor in front of her recliner. (R72) sustained a laceration of the right eyebrow that required sutures. After (R72's) fall on 11-29-19, we decided to implement a body alarm to (R72) at all times to prevent further falls. On 12-16-19 (R72) had gotten up out of bed and fell in the doorway of (R72's) room. (R72) sustained a fracture to the left hip from that fall."

On 2/04/20 at 12:35 PM, V9 (ADON) stated, "(R72) should have had a body alarm when she fell on 12-16-19. I was the one that completed (R72's) fall investigation and faxed the investigation to the state agency. The report to the state agency documented that (R72) would have a body alarm applied. I updated (R72's) care plan with the new fall intervention to apply a body alarm to (R72) at all times to alert staff when (R72) attempts to get up on her own. I was walking up the hallway the day (R72) fell (12-16-19) and did not hear an alarm sounding

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when (R72) fell. I was not aware that anyone had discontinued (R72's) alarm off of the care plan."

On 2/04/20 at 2:17 PM, V3 (R72's Physician) stated, "(R72) was admitted to the facility from an assisted living facility due to (R72) falling and needing more help with cares. I am not involved in developing fall interventions in the facility. The nursing supervisors develop fall interventions. Whatever fall interventions were developed for (R72) should have been implemented and followed. (R72's) fall directly caused the right hip fracture."

On 2/05/20 at 10:10 AM, V11 (CNA) stated, "I am going to be honest. I do not know where to find what (R72's) fall interventions are. I was not aware that we (facility staff) are to try to encourage (R72) to sit in common areas. I am not aware of a care plan book being available with (R72's) care plan. I thought we were suppose to take (R72) to her room and put her in the recliner whenever she was not in activities or eating."

On 2/05/20 at 10:20 AM , V12 (CNA) stated, "I know I can find fall interventions on the computer. I am not aware of a care plan book with care plans. (R72) is supposed to be in her room in the recliner or in activities."

On 2/05/20 at 10:36 AM, V13 (CNA) stated, "I have worked here for about five years. I was (R72's) CNA on the day (R72) fell (12-16-19). I had put (R72) in the recliner that day and she had gotten up by herself and fell. I know (R72) was supposed to have an alarm on. (R72) had an alarm for approximately two weeks prior to this fall. I do not know why (R72) did not have her alarm on the day of her fall (12-16-19). I did not know that (R72) was to be encouraged to sit in

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S9999	Continued From page 7 common areas. (R72) was in her room alone prior to the fall." On 2/05/20 at 11:29 AM, V2 stated, "I do not know who discontinued (R72's) body alarm fall intervention off of (R72's) care plan. The alarm should not have been discontinued. The alarm was implemented after (R72's) fall on 11-29-19. I should have been aware if some one discontinued (R72's) alarm since I am the Director of Nursing. I will be finding out who discontinued that alarm." On 2/05/20 at 12:15 PM, V1 (Administrator) stated, "When I was notified about (R72's) fall on 11-29-19, I made the decision to discontinue (R72's) alarm. I did not let (V2) know, that was my decision. The staff were supposed to bring (R72) out to the common areas and not leave (R72) in her room alone. Staff should have known to bring (R72) out to common areas." (B)	S9999		