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 _____	C 06/01/2022

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 Investigation of Facility Reported Incident of May 11, 2022/IL147131	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. These requirements were not met as evidenced by: Based on record review and interview, the facility failed to implement interventions as outlined in a fall prevention plan of care and provide toileting assistance, for one of three residents (R1) reviewed for falls, in a sample of three. These failures resulted in R1 falling, hitting the left side of her head, and sustaining a large acute subdural hemorrhage on 5/11/2022, and subsequently dying later that day. Findings include: The Fall Risk Prevention and Monitoring Policy (no date), documents, "1. The Fall Risk Assessment Process begins prior to the resident's admission to the facility via the nurse	S9999		

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S9999	Continued From page 2 liaison, social service designee, and DON (Director of Nursing)/Nurse Admin Team consultation about resident history information. Parameters are assessed via the nursing assessment and history. Fall histories are obtained as well as current prevention strategies that may have been used in the resident's previous setting, such as bed checks, (high/low) beds, etc. 2. The fall risk assessment will be completed upon admission, quarterly and with significant changes. 3. Evaluate risk factors and develop interventions to address the risk factors. 4. Prevention interventions will be established based upon risk factors, not total score. 5. If prevention strategies have been unsuccessful and an incident occurs, resident specific trends/patterns will be identified to further assess the prevention need. 6. If a fall occurs, the nurse on duty will do a complete assessment and follow the physician notification policy and procedure. 7. An incident report will be completed entirely, including but not limited to: Assessment of the conditions - what caused the fall, addressing the contributing factors - Investigation Process; Implementing resident specific interventions to prevent further occurrences; notifying the POA (Power of Attorney) and physician; Care planning the event on the care plan and adding interventions to the resident's care plan; Determine if the incident is medication related, if so send a (medication review) to the pharmacy." The Electronic Medical Record documents R1 was admitted to the facility on 4/27/22, with the diagnoses of Difficulty Walking, Muscle Atrophy, Abnormal Gait, Lack of Coordination, weakness and Atrial Fibrillation. A Fall Risk Assessment, completed on 4/27/22, determined that R1 was at "moderate risk" for falling. A Plan of Care, initiated on 4/27/22, documents "(R1) is at risk for	S9999		

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falls due to periods of increased confusion, incontinence, unsteady/shuffling gait, and medications she receives. She does not always remember to ask for staff assistance with transfers/ambulation and requires frequent reminders to do so" and instructs staff to "provide toileting assistance every 2 hours and as needed." The Plan of Care also documents "(R1) has difficulty making her needs known and understanding others at times due to cognitive impairment, with periods of increased confusion and expressive aphasia. She needs monitoring for verbal, as well as nonverbal, indicators of needs." A Minimum Data Set assessment, dated 5/03/22, documents R1 has significant cognitive impairment, is only occasionally incontinent of urine and is continent of bowel, and requires extensive assistance of one staff member for toileting.

A Nursing Progress Note dated 5/11/22 at 3:19 am, documents "(R1) was found on the floor of the room across from hers at (2:45 am) after a sound was heard when she fell. She states, 'I bumped my head.' She is assisted to a sitting position in a wheelchair. Her left occipital region has a quarter sized bump which has an ice bag applied. Her vital signs and neuro checks are normal. She has full range of motion of her extremities." A Post Fall & Neuro-Check Assessment dated 5/11/22, documents R1 had visible left occipital bruising. The next Nursing Progress Note, on 5/11/22 at 7:27 am, documents "(R1) showed no changes throughout the night neurologically as neuro checks were done per protocol. Vital signs showed no change staying around 130/68 (blood pressure), 98.6 tympanic (temperature), 60 (pulse), and 16 (respirations). At 6:30 (a.m.) she showed more lethargy and was not responding verbally. At

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S9999	Continued From page 4 (6:50 am) she was unresponsive. (Emergency Medical Services) was alerted and she was transported to (Emergency Room)." A CT (Computed Tomography) scan of R1's brain, dated 5/11/21 at 8:45 am, documents R1 sustained a "large acute left cerebral convexity subdural hemorrhage with 1.3 cm (centimeters) of left-to-right midline shift and subfalcine herniation, mild left uncal medialzation and early central herniation. Recommend emergent neurosurgery consultation if within goals of patient care." Hospital Records, dated 5/11/22, document no surgical intervention was provided for R1, she was placed on Hospice and comfort measures only and expired shortly after. R1's Death Certificate, dated 5/11/22, documents R1's immediate cause of death as Subdural Hematoma, related to a fall. The facility's Incident Report for R1's fall, dated 5/11/22, documents "Investigation revealed that at (2:38 am) on (5/11/22, R1) ambulated independently out of her room across hall to room 107 where an unwitnessed fall occurred. Staff immediately responded to the sound as a result of fall. (R1) was found lying on the floor of room, where she reports she bumped her head. (R1) told the staff she was looking for the bathroom. (R1) had been observed sleeping comfortably in passing (approximately) 20 (minutes) prior to the fall. At the time of the fall, (R1) denied pain. (Neurological) checks and vitals were (normal). (R1) was assisted back to room, toileted and placed back in bed. (R1's) pressure pad alarm was found to be turned off and not sounding at the time of fall. Post fall huddle reveals at the time of last rounds, pressure pad was under resident and functioning. It appears that (R1) turned off the alarm. (R1) has had no falls during admission or in the last month prior to admission.	S9999		

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S9999	Continued From page 5 Due to confusion and lack of safety awareness to ask for help, a pressure pad alarm had been put in place after admission. (Neurological) checks were initiated per protocol and remained normal until (approximately 6:30 am), when (R1) became more lethargic and at (approximately 6:45 am) was non-responsive. (Emergency Medical Service) was called and resident sent to (Emergency Room) for further evaluation. (Power of Attorney and Physician) were notified. The above-mentioned subdural hemorrhage was discovered, and neurosurgery consulted. (Power of Attorney) made decision that resident would not want extreme measures taken. (R1) was admitted to hospital for comfort care and passed away at (2:49 pm)." On 5/31/22 at 12:29 PM, V7 (Certified Nursing Assistant) stated on 5/10/22 at approximately 7:30 pm, she toileted R1, put R1 to bed for the night and made sure her pressure alarm was working and in place. V7 stated she checked on R1 after that, and R1 stayed in bed then for the remainder of her shift, which was over at 11:00 pm, but she did not toilet R1 again. V7 indicated she was unaware R1's Plan of Care directed staff to toilet R1 every two hours and as needed. On 5/31/22 at 12:18 PM, V5 (Certified Nursing Assistant) stated R1 was in bed sleeping when she started her 11:00 pm shift on 5/10/22. V5 stated she did her "rounds" on all of the residents every two hours, which included checking in on them and maybe taking vital signs. V5 stated R1 was asleep in bed with the pressure alarm in place each time she did her rounds, and she did not get R1 up to toilet at any point. According to V5, at approximately 2:30 am, she heard a "boom" down the hallway. V5 and V8 (Certified Nursing Assistant) looked for the source of the	S9999		

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noise and found R1 on the floor of another resident's room. V5 stated R1 had "peed on herself" and R1 indicated she was looking for a bathroom. V5 stated she was unsure of when R1 was last toileted, but thought she was likely taken to the bathroom before bed. V5 was unaware R1's Plan of Care directed staff to toilet R1 every two hours and as needed.

On 6/01/22 at 10:01 am, V6 (Lead Certified Nursing Assistant) stated it is her responsibility to help guide Certified Nursing Assistant (CNA) staff in resident care needs. V6 confirmed that she was working on 5/11/22 when R1 fell but did not arrive in the room R1 fell in until V5, V8 and V4 (Registered Nurse) were already assisting her. V6 stated R1 appeared unstable, had a visible injury to the side of her head, had urinated on herself and was being assisted to a wheelchair at that time. V6 stated she has the CNAs rely on a written list that is made for each hallway, which identifies each individual resident's care needs during nightly rounds. V6 indicated, if a resident's plan of care identifies that they are to be toileted every two hours, that information is to be on that written list.

On 6/01/22 at 2:00 pm, V2 (Director of Nursing) stated the facility does not keep the written task list for each hallway that the CNAs use, because that information changes almost daily; however, V2 stated that task list should be reflective of each individual resident's plan of care. At 3:00 pm, V2 stated she reviewed video surveillance from the night of the fall, and the only time someone was in R1's room for a length of time that would allow for toileting was at 10:37 pm on 5/10/22, but she did not interview that staff member to determine if R1 was actually toileted at that time. V2 stated the video surveillance she

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S9999	Continued From page 7 reviewed did show staff "rounding" on R1, but nothing further. V2 stated her investigation into R1's fall on 5/11/22 did conclude that R1 had not been toileted every two hours, or even at all during the night as directed per R1's Fall Prevention Plan of Care, and R1 was looking for a bathroom when she fell. (A)	S9999		