STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6000962	A. BUILDING: _____ B. WING _____	C 02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIG MEADOWS	1000 LONGMOOR SAVANNA, IL 61074

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S 000	Initial Comments Annual Licensure Survey Investigation of Facility Reported Incident of February 18, 2025/IL186659	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b)4) 300.1210c) 300.1210d)3)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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resident to meet the total nursing and personal care needs of the resident.

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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.

This REQUIREMENT is not met as evidenced by:

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Based on observation, interview, and record review the facility failed to implement care planned interventions to reduce a dementia resident's anxiety and aggressive behaviors. This failure resulted in R49 fracturing a finger on his left hand after punching a wall. This failure applies to 1 of 9 residents (R49) reviewed for dementia care in the sample of 16.

The findings include:

A facility incident report dated 2/18/25 showed R49 became agitated during cares and "swung out at CNA (certified nursing assistant). While swinging at the CNA, he hit the wall as he was in bed and the bed was pushed up against the wall. X-ray was completed and shows acute fracture of proximal phalanx 3rd finger with mild deformity ..."

R49's admission record dated 8/30/24 showed R49 had diagnoses of anxiety and dementia with behavioral disturbances.

R49's behavior note dated 12/20/24 showed R49 "started hitting staff, was at the front door hitting the glass" after becoming agitated and anxious.

R49's behavior note dated 1/7/25 showed, "Resident becomes very anxious, sometimes agitated and restless around 6 or 7 pm almost every night ..."

R49's current care plan showed, "The resident is/has potential to be physically aggressive due to not understanding need for help with ADLs (activities of daily living) related to dementia ...

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The care plan showed behavioral interventions for R49 as "resident's triggers for physical aggression are wanting to be left alone. The resident's behaviors is de-escalated by offering a (brand name soda) or calling son ... When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later." The care plan showed R49 was cognitively impaired.

On 2/24/25 at 9:30 AM, R49 was seated in a recliner in his room. R49's second, middle, and ring fingers on his left hand were swollen and bruised. When R49's was asked what had happened to his left hand, R49 stated, "I don't know."

On 2/24/25 at 12:52 PM, V4 (CNA) stated she was the CNA providing cares to R49 on 2/18/25, at the time of the incident. V4 stated, "It (the incident) happened sometime in the middle of the night. His CNA had gone on lunch break, so I was watching that assignment while she was gone. I knew (R49) had a history of yelling and hitting but I didn't know at that time that he had been having behaviors all night. His CNA didn't report he had been having behaviors to me before she went on lunch." V4 stated she heard R49's safety alarms going off, so she entered R49's room. She found R49 seated on the side of his bed. R49 was incontinent. V4 stated, "I helped him lay down in bed so I could change him. I rolled him on his side (on his bed). He never said anything but that's when he started punching the wall. I probably should have given him a break. I was in the middle of changing him, so I just kept trying to get him changed. He continued to swing with his arm. That's when he

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hit me too. He punched me while I was trying to get his brief on." V4 stated she was unaware that R49 had injured his left hand at the time.

On 2/25/25 at 10:30 AM, V7 (CNA) stated she was R49's assigned CNA on 2/18/25. V7 stated on 2/18/25, R49 had been having verbal and physically aggressive behaviors "that evening" prior to the incident. V7 stated, "He was cussing at me. He threatened my job. He tried to hit me when I changed him.... Usually, if you let him settle down and re-approach him, he will settle down..." V7 stated she did not inform V4 (CNA) that R49 had been having behaviors that night prior to V7 taking a break for lunch. V7 (CNA) stated, "I just assumed everyone knew (R49) had been having a bad night."

On 2/24/25 at 1:19 PM, V5 (Social Services Director) stated, "(R49's) behaviors stem from him wanting to be left alone, his confusion and him being hard of hearing. He has had physical behaviors of kicking and hitting but they are usually because he wants to be left alone... If he is having behaviors, it's best for staff to leave him alone and re-approach later. I have told staff that if he safe and is having behaviors, walk away and re-approach after he calms down. Calling his son or offering him a (brand name soda) also helps to calm him down."

On 2/25/25 at 11:07 AM, V6 (Physician of R49) stated R49 was admitted to the facility because of his dementia and his family could not manage him at home. V6 stated, "All staff should be aware of the different strategies to de-escalate a resident's dementia related behaviors as per their care plan. The goal is to use non-pharmacological behavioral interventions first..."

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S9999	Continued From page 5 The facility's Behavioral Management policy (undated) showed, "It is the goal to provide a Behavioral Management Program that will differentiate the diagnosis of "behavioral symptoms" so that the underlying cause of the symptom is recognized and treated appropriately... Procedure: Develop a Behavior Management Program, if appropriate, with identification and implementation of interventions... All residents of Behavior Monitoring/Management should have interventions noted on the individual resident's care plan..." "B"	S9999		