STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145596	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Village	1200 East Partridge Metamora, IL 61548

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34048 Based on observation, interview, and record review, the facility failed to ensure the hot water sanitation rinse cycle was maintained and failed to run test strips to test the surface temperature of the dishwasher. This has the potential to affect all 74 residents residing in the facility. Findings include: The facility's Dishwashing Machine policy, dated 2011, documents the following: The dining services staff shall maintain the operations of the dishwashing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food. This form documents to check the dishwashing machine each morning before first set of dishes are to be washed. If the dishwashing machine has not been used for several hours, it is generally recommended to allow the dishwashing machine to cycle for one or two cycles to allow the dishwashing machine to heat up. The facility's Dishwasher Instructions,, revised 12/96, documents, The minimum water temperatures for the hot water wash is 150 degrees Fahrenheit, and the rinse is 180 degrees Fahrenheit. On 3/24/25 at 09:32 AM, a kitchen tour was conducted with V4, Dietary Manager/DM. The dishwashing machine hot water wash cycle temperature gauge documented 159 degrees Fahrenheit, and the rinse cycle temperature gauge documented 178 degrees Fahrenheit. V4 stated the temperature gauge on the dishwashing machine is used to determine the accuracy of the high temperature rinse cycle. At that same time, V4 stated no other testing is done, and V4 has never used test strips to check the temperature of the water. V4 verified the rinse temperature should reach at least 180 degrees Fahrenheit. On 3/24/25 at 12:45 PM, V1, Administrator, stated a test strip has never been done to check the internal hot water wash and rinse cycle temperatures of the dishwashing machine. The facility's Resident Bed List Report, dated 3/25/25, documents 74 residents reside in the facility.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32189 Based on observation, interview, and record review, the facility failed to ensure infection control and prevention practices were utilized per policy for three (R13, R45, R55) of 24 residents reviewed in a sample of 24. This failure has the potential to affect all 74 residents who reside in the facility. Findings include: The Transmission-Based (Isolation) Precautions policy, dated 10/24/22, documents, Contact precautions refer to measures that are intended to prevent transmission of infectious agent which are spread by direct or indirect contact with the resident or the resident's environment. High touch objects and environmental surfaces should be cleaned and disinfected with an EPA/Environmental Protection Agency-registered disinfectant for healthcare use at least daily and when visibly soiled. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicate in transmission through environmental contamination (Clostridium-difficile). Residents experiencing fecal incontinence or diarrhea that cannot be contained and suggest an increased potential for extensive environmental contamination and risk of transmission of a pathogen, should be placed on contact precautions. The Enhanced barrier Precaution (EBP) policy, dated 3/20/24, documents, EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organism that employs targeted gown and gloves during high contact resident care activities. EBP will be initiated for residents with wounds and a physician's order is not required. EBP will be identified by a small sign reading EBP placed on the door frame. PPE for EBP is only necessary when performing high-contact care activities. High-contact resident care activities include wound care. The Hand Hygiene policy, dated 1/30/24, documents, The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning and doffing gloves and immediately after removing gloves. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, documents, To conduct hand hygiene before moving from work on a soiled body site to a clean body site on the same patient and immediately after glove removal. When to change gloves and clean hands: if gloves become soiled with blood or body fluids after a task, if moving from work on a soiled body site to a clean body site on the same patient or if a clinical indication for hand hygiene occurs. C-difficile is a spore-forming bacterium that can lead to a common healthcare-associated infection causing severe diarrhea. Spores are inactive form of the germ and have a protective coating allowing them to live on surfaces for months. The CDC's Infection Control Appendix A: Figure. Example of Safe Donning and Removal of Personal Protective Equipment (PPE) documents A gown should gown fully cover torso from neck to knees, arms to end of wrist, and wrap around the back and fasten in back at neck and waist. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Standard Precautions Policy, undated, documents the following: All staff are to assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing care services. 1. R13's Facesheet documents R13 was admitted on [DATE], with diagnoses of Hypertensive Chronic Kidney Disease, Venous Insufficiency, Major Depressive Disorder and Generalized Weakness. On 2/19/25, R13 returned from a hospital stay with diagnoses of Clostridium Difficile (C-diff/Infection of the large intestine), Sepsis (Infection in the blood stream), Pneumonia, Acute Respiratory Failure, and Gastro-Esophageal Reflux Disease with Esophagitis. R13's Stool Culture results, dated 3/21/25, documents R13 tested positive for C-difficile, and antibiotics were ordered. R13's Physician Order, dated 3/13/25, documents to initiate Contact Precautions/Isolation for C-difficile infection. On 3/25/25 at 10:05 AM, R13's door frame had a Contact Precaution sign posted and a sign with instructions to wash hands with soap and water. R13's bathroom had brown substance (stool) on toilet seat, toilet base, and on floor from the doorway to the toilet. The bathroom sink was the only sink available for hand hygiene, and staff would have to walk through the door and past the toilet to get to the sink. On 3/25/25 at 11:00 AM, V5 (Registered Nurse) went into R13's Contact Isolation room and administered medications and cleaned the bathroom. V5's gown was not tied in the back. On 3/25/25 at 10:05 AM, R13 stated she is still having diarrhea stools and had a mess in the bathroom. 2. R55's Face sheet documents R55 was admitted on [DATE], with diagnoses of Closed Fracture Right Femur, Muscle Wasting and Atrophy, Diabetes Mellitus Type 2, Glaucoma, Sacral Wound and Anemia. R55's Physician Order, dated 3/6/25, documents to apply collagen sheet into the coccyx wound and cover with calcium alginate and bordered gauze daily. On 3/25/25 at 1:55 PM, V5 (Registered Nurse) was observed to open the treatment cart, remove dressing change supplies and scissors. V5 proceeded to open the collagen package, cut the collagen sheet with scissors from the drawer without cleaning them, then opened the calcium alginate package and walked down the hall to R55's room to conduct wound care on R55. On 3/25/25 at 2:01 PM, R55's doorframe had an EBP sign posted. On 3/25/25 at 2:01 PM, V5, RN, donned a PPE gown and did not button the front of the gown up. At that same time, R55's sacral wound dressing change was conducted. V5 removed R55's dirty dressing and V5 removed gloves and donned new gloves without conducting hand hygiene. On 3/25/25 at 10:50 AM, V2, DON/Director of Nursing, agreed a staff member would have to walk through the brown substance (stool) to get to the sink to wash hands, and could potentially contaminate the environment outside of R13's room. V2 stated, I will get that cleaned up immediately. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/27/25 at 11:30 AM, V2, DON, stated, All gowns should have been secured in the back; hand hygiene should have been conducted after gloves were removed; (R13's) bathroom should have been cleaned as soon as possible after being soiled; the wound dressing should have been opened at (R55's) bedside; and scissors should have been disinfected prior to use and prior to placing them back in the treatment cart. On 3/27/25 at 2:20 PM, V1 (Administrator) stated, We like to keep nurses on the same unit because they get to know their residents. It's stable staffing but of course, if someone needs assistance or whatever, the nurses can go anywhere in the facility to care for residents. 31285 3. On 3/25/25 at 10:15 AM, V4, CNA/Certified Nursing Assistant, provided incontinence care for R45, who was incontinent of stool. V4 did not change gloves after providing incontinence care for R45's bowel movement. At that same time with the same soiled gloves, V4 rolled R45 side to side in bed and placed a clean incontinence brief under R45. With the same soiled gloves, V4 then assisted V6, CNA, with placement of a full mechanical sling under R45 and transferred R45 from his bed into a wheelchair. During R45's transfer, V4 supported R45 and positioned him over the wheelchair while in the sling, and V6 lowered R45 into the wheelchair using the mechanical lift's controls. On 3/25/25 at 10:30 AM, V4, CNA, verified she did not change her gloves or perform hand hygiene throughout R45's incontinence cares and transfer. On 3/26/25 at 1:45 PM, V2, DON/Director of Nursing, stated gloves should be removed, hand hygiene performed, and clean gloves donned after performing incontinence cares and before placing a clean incontinence brief for a resident. The facility was unable to provide a policy identifying appropriate infection control procedures for the donning and doffing of gloves during incontinence care. The facility was also unable to provide a policy and procedure for incontinence care. The facility's Resident Bed List Report, dated 3/25/25, documents 74 residents reside in the facility.