

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
NAME OF PROVIDER OR SUPPLIER Snyder Village		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to store controlled medications safely to prevent potential unauthorized access and failed to store medications under verified proper temperature controls. This failure has the potential to affect all 70 residents currently residing in the facility. The facility policy, Medication Storage, dated (revised) 01/30/2024 directs staff that it is the policy of the facility to ensure all medications housed (in the facility) will be stored in medication rooms according to manufacturer's recommendations to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. Narcotics and Controlled Substances such as Schedule II drugs and back up Schedule III, IV and V medications are stored under double-lock and key. On 4/29/2026, at 10:47AM, an observation of the facility Central Nurses Station Medication Room, with V13/Registered Nurse present, a white medication refrigerator was present. No medication temperature log was present. At that time, V13/RN stated she did not know whose responsibility it was to obtain and document the daily required temperature check. Upon opening the unlocked medication refrigerator, a thick buildup of residue was noted on the door seal and covering the bottom of the refrigerator. An unsecured, removable locked red metal box and a plastic tackle box were present on the bottom shelf. With V2/Director of Nurses present, upon opening the red container, a 30 ML (milliliter) bottle of Lorazepam (schedule IV-controlled substance) 2 MG (milligrams)/ML bottle was present. The plastic tackle box contained two bottles of Lorazepam 30 ML, 2MG/ML. At that time, V2 stated the third shift staff were responsible for checking the facility medication refrigerator temperatures and had not been doing so for the past few months. V2/DON confirmed the dirty medication storage refrigerator and the lack of the medication being stored in a locked permanently affixed container. The Centers for Medicare and Medicaid Services form 671, dated 4/30/2026 and signed by V3/Executive Director, documents 70 residents currently 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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to offer bedtime snacks to all residents. This has the potential to affect all 70 who reside within the facility. Findings include: The facility's CMS (Centers for Medicare and Medicaid Services) Form 671, dated 4/30/26 and signed by V3/Executive Direct (Administrator), documents 70 residents reside within the facility. The facility's Health Center Snack Policy, dated 3/1/25, documents, Policy: The facility shall provide an organized snack program to ensure residents have access to nutritious food between the evening meal and breakfast. Snacks will be of nourishing quality, consistent with individual dietary needs, and offered in a manner that promotes resident choice, dignity, and adequate nutritional intake. The facility's Resident Council Minutes, dated 12/16/25, documents, New Business: 6) Feedback for Departments: b. Dietary: The last meal is finished early so dietary ask Certified Nursing Assistants to get resident to dining room early so they can leave early. This leaves too many hours between lunch and breakfast, and the snacks are not passed, only for those who can ask for it. R8, R15, R29, R35, and R72's electronic health records do not contain documentation of R8, R15, R29, R35, and R72 being offered or receiving bedtime snacks. On 4/28/26 at 1:36 PM, R8, R15, R29, R35, and R72 all stated they never get offered snacks at bedtime. R15 stated the facility did away with going around and offering all residents a snack at bedtime that could have one around a year ago. R8, R15, R29, R35, and R72 all denied being told they must ask for a snack and stated they would like snacks to be offered at bedtime again. On 4/28/26 at 2:00 PM, V2/Director of Nursing stated snacks are not routinely offered at bedtime and the residents know snacks are available upon request and the residents must hit their call light to request one. On 4/28/26 at 10:45 PM, V3/Executive Director verified bedtime snacks are not automatically provided to all residents. Instead, snacks are available upon request, requiring residents to proactively ask if they would like one.		

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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. Based on observation, interview and record review, the facility failed to ensure proper hair restraints were worn in the kitchen and while preparing food, repackaged frozen food items were labeled, the quaternary sanitation bucket contained an adequate level of chemical to sanitize the kitchen, cool down temperatures were monitored and recorded for foods cooked then refrigerated, and ensure the dish machine testing strips monitored the required level of heat sanitation during the dishwashing cycle for a high temperature dishwasher. These failures have the potential to affect all 70 residents residing in the facility. Findings include: The facility's Dining Service Hair Restraint policy, dated 4/4/25, documents, Staff members entering food preparation, dishwashing, or service areas must wear effective hair restraints to prevent hair from contaminating food, food-contact surfaces, and equipment. All individuals working in or entering food preparation, dishwashing, or services areas must wear appropriate hair restraints at all times. Acceptable hair restraints include: Hairnets, [NAME] nets (for individuals with facial hair), Caps or hats that fully contain the hair. Hair restraints must effectively cover and restrain all head hair, including bangs and loose strands. Staff members with beards, mustaches, or other facial hair must wear beard restraints when working with exposed food or clean equipment and utensils. The facility's Dining Service Cold Storage policy, dated 4/4/25, documents, To ensure all food is stored under safe temperature conditions to prevent foodborne illness and comply with (state) regulations governing long-term care facilities and food sanitization. This policy also documents Ready to eat foods held over 24 hours must be clearly marked. Used or discard within seven days at less than or equal to 41 degrees Fahrenheit (F). Cooked foods must be cooled from 135 degrees F to 70 degrees F within two hours and from 70 degrees F to 41 degrees F within four additional hours. The facility's Cooling Monitoring Form policy, dated 3/25/19, documents, Using the cooling monitoring form record temperature of food every hour. The food should be cooled from 140 degrees F to 70 degrees F within two hours and cooled from 70 degrees F to 41 degrees F within four additional hours. If the temperature does not reach 70 degrees F in two hours, or 41 degrees F in an additional four hours, reheat to 165 degrees F and start the cooling process again or discard the product. Reheating could compromise the quality of the food. The facility's Dining Service Sanitation policy, dated 4/4/25, documents, To ensure proper cleaning and sanitizing of food-contact surfaces in accordance (state agency) and FDA (Food and Drug Administration) Food Code requirements. Verify concentration using quat (quaternary ammonium) test strips. Acceptable concentration range: 200-400 ppm (parts per million) or per manufacturer label. The facility's Dining Service Dishwashing policy, dated 4/4/25, documents, All dishes, utensils, and kitchen equipment shall be washed, rinsed, and sanitized using approved methods and equipment. This policy also documents Machines must reach required temperatures: High-temp machines; wash 150-165 degrees F; final rinse at least 180 degrees F. Temperatures and sanitizer levels must be checked and recorded daily. On 4/27/26 at 9:30 AM V4 (Dietary Manager), V6 (Cook), and V5 (Dietary Server) were in the facility's kitchen. V4 was wearing a hat with approximately four inches of hair sticking out the back of her hat, unrestrained. V6 was wearing a baseball style hat with a ponytail of hair sticking out from under the back of the hat, unrestrained. V6 was also wearing a paper mask over his facial beard with facial hair sticking out from both sides of the mask. V5 was wearing a baseball style hat with about two to three inches sticking out from under the back of the hat, unrestrained. At this time, V4 stated, Staff can either wear a hairnet or a hat while in the kitchen. On 4/27/26 at 9:40 AM, during the kitchen tour, the facility's walk-in cooler contained a metal pan of cooked chicken tenders, dated 4/24. V4 (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(Dietary Manager) stated, These were cooked, cooled, and then will be placed on buns for a grab and go option. The walk-in freezer contained a metal pan with several snack size zipper plastic bags of diced meat. These bags and the pan did not contain a label, date, or date of expiration. V4 stated, This is diced ham for residents on feeding programs. V4 confirmed they should be labeled and dated. The kitchen sink near a food preparation counter contained a red bucket with water and rags. V6 (Cook) confirmed this bucket contained a quat solution and is used to wipe food services. V4 took a testing strip and checked the level of quat in the bucket. V4 and V6 confirmed with two strips that the quat level testing strip did not change color, indicating the sanitation solution chemical level was zero and not high enough for sanitation. V6 stated he just filled the sanitation bucket approximately an hour prior and that he usually changes the solution about every two or three hours. On 4/27/26 at 10:05 AM, the kitchen's April 2026 cool down log was reviewed, and the most recent entry was made on 4/21/26 for cooling of gravy. V4 confirmed the chicken tenders in the walk-in cooler that were dated 4/24, are not on the cool down log. V4 stated, I don't see a cool down for the chicken strips that are in the cooler and those will need to be discarded. On 4/27/26 at 10:10 AM, V9 (Dishwasher/ Server) stated the dish machine used in the kitchen is a high temp dishwasher and the temperature testing strips turn black when water reaches 160 degrees F. V4 (Dietary Manager) confirmed the rinse cycle internal temperature is checked with the dish-machine testing strips. V4 stated the strip will turn to black with a temperature of 160 degrees F and that there is no other thermometer or tests completed to ensure the dish machine's rinse cycle reaches 180 degrees F. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671, dated 4/30/26 and signed by V3 (Executive Director), documents 70 residents reside within the facility.		

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure residents and resident representatives were explained arbitration agreements accurately prior to signing upon admission to the facility. This failure has the potential to affect all 70 residents residing in the facility. Findings include: The facility's Binding Arbitration Agreements policy, dated 1/30/24, documents, This facility asks all residents to enter in an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to, or as a requirement to continue to receive care at this facility. Binding Arbitration is a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds. This policy also documents When explaining the arbitration agreement, the facility shall: Explain to the resident and his or her representative in a form and manner that her or she understands, including in a language the resident and his or her representative understands. Ensure the resident or his or her representative acknowledges that he or she understands the agreement. The facility's admission contract (undated) Arbitration section, documents, Should the parties fail to reach a resolution of any claim, dispute, or controversy described by way of mediation, the dispute shall be arbitrated in accordance with the American Arbitration Association (AAA). By agreeing to arbitration of all disputes, the resident and/or resident's representative and the facility are waiving a jury trial for all claims, disputes, and controversies referenced in this paragraph. The parties agree that this agreement to arbitrate shall survive and not otherwise be revoked by the death or incompetency of the resident. The award cost of the arbitration shall be determined by the arbitrator in accordance with state law. On 4/29/26 at 2:20 PM, V3 (Executive Director) stated, We do not have arbitration agreements, but everyone has signed the arbitration section in the contract. All of the residents here have signed an admission contract and initialed arbitration portion. I don't believe anyone has refused. On 4/29/26 at 2:45 PM, V17 (Social Service Coordinator) confirmed she is the person who goes over the admission contracts with all residents and families. V17 stated, I am more versed on the contract than other staff and have been doing them since November 2025. There is a dispute resolution in the contract that speaks mostly to non-payment and steps include mediation and then arbitration. I explain to them that if there is an issue with non-payment then that can be settled first with mediation and then arbitration. I am not aware of the arbitration agreement having anything to do with a resident's ability to sue the facility or that is has anything to do with a care or injury dispute. I do not tell them that they are giving up their rights to a jury trial or the ability to independently sue the facility. That is not something I am aware of. V17 confirmed she was trained on admission contracts and is completing them the same as they have always been when someone is admitted to the facility. V17 confirmed everyone in the facility has a signed admission contract which includes an arbitration agreement portion. On 4/30/26 at 10:15 AM, V18 (R50's family member) stated he is the one who signed paperwork for R50's admission in March 2026. V18 stated it was V17 who went over the admission contract and he does not recall anything about mediation or arbitration being explained or discussed with them. The facility's CMS (Centers for Medicare and Medicaid Services) Form 671, dated 4/30/26 and signed by V3 (Executive Director), documents 70 residents reside within the facility.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure appropriate oversight of medication administration for one of ten residents (R65) reviewed for medication oversight in a sample of 36. Findings include: The facility's Resident Self-Administration of Medication Policy, dated 1/30/24, documents, Policy: The facility supports each resident's right to self-administer medication. A resident may only self-administer medications after the interdisciplinary team has determined which medications may be self-administered safely and physician order is obtained. Policy Explanation and Compliance Guidelines: 1. Each resident may be considered for self-administration of medication, if requested and deemed capable and appropriate with physician order. 2. Resident's preference will be documented on the care plan and placed in the medical record. R65's admission Record documents R65 is an [AGE] year-old female who was admitted to the facility on [DATE], with the following diagnoses: Essential Hypertension, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease, Retention of Urine, and Chronic Respiratory Failure. R65's MDS (Minimum Data Set) Assessment, dated 4/6/26, documents R65 is cognitively intact. R65's Order Summary Report, dated 4/28/26, documents the following Physician Order Order Date: 3/31/26- Lasix 80 milligrams give one tablet by mouth three times a day related to Essential Hypertension. R65's Electronic Medical Record lacked documentation of any orders, care plan, or assessments for self-administration of medications, or any orders for R65's medications to be left at her bedside. On 4/27/26 at 10:18 AM, R65 was observed in her room with a bedside table positioned in front of her. A clear medicine cup containing a single round white pill was on the table. R65 explained the nurse typically leaves her Lasix in the cup in the morning for her to take at a later time. On 4/29/26 at 11:03 AM, V15/Licensed Practical Nurse verified she left R65's Lasix unattended in a medication cup in R65's room. V15 explained R65 often prefers to delay the dose until after therapy. V15 noted while she occasionally waits to administer the medication herself to R65, she also leaves it in R65's room for R65 to self-administer later. On 4/29/26 at 12:44 PM, V2/Director of Nursing verified R65 does not have an assessment for self-administering her own medications or a care plan/order to self-administer medications. V2 stated she was not aware R65's Lasix was being left in her room to take on her own, and stated R65 should not administer any medications herself without supervision, and medications should not be left on her bedside.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an appropriate indication for the use of an antipsychotic medication, monitor targeted psychotic behaviors to warrant the use of Seroquel (antipsychotic) medication, and failed to ensure a clinical rationale and justification was established by a physician for the continued use of Lorazepam (anti-anxiety) PRN (as needed) medication beyond the 14-day evaluation period, for two of five residents (R2 and R13) reviewed for psychotropic medications in the sample of 36. Findings include: The facility's Psychotropic Medication Policy, dated 4/4/25, documents, Policy: The facility ensures that psychotropic medications are used only when clinically indicated, in the lowest effective dose, for the shortest duration necessary, and in accordance with resident rights, IDPH (Illinois Department of Public Health) regulations, and federal requirements. Psychotropic medications are not used for staff convenience or as a chemical restraint. Definitions: Psychotropic Medications- Drugs affective mood, behavior, or mental processes, including: (1) antipsychotics, (2) antidepressants, (3) anti-anxiety agents, and (4) mood stabilizers. Unnecessary Drug: Any medication that is excessive in dose or duration, lacks adequate indication, lacks monitoring, or results in adverse consequences without appropriate adjustment. Procedures and Guidelines: Psychotropic medications may only be used when (1) there is a documented diagnosis or target symptom, (2) the medication is clinically justified and beneficial, (3) benefits outweigh risks and contraindications. 1. R2's admission Record documents R2 is an [AGE] year-old male who was admitted to the facility on [DATE], with the following diagnoses: Unspecified Dementia (unspecified severity) with other Behavioral Disturbance, Gout, Anxiety Disorder, Retention of Urine, and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. R2's MDS (Minimum Data Set) Assessment, dated 4/17/26, documents R2 is severely cognitively impaired and receives an antipsychotic medication. R2's Psychiatry Initial Evaluation, dated 3/12/26 and signed by V12/Behavior Advance Practical Nurse, documents a past medical history of the following: Anxiety, Dementia with Behavior Disturbance, Obstructive Uropathy with Urinary Tract Infection, Benign Prostatic Hyperplasia, Hypertension, Abnormal Gait, Irritable Bowel Syndrome, and Diverticulitis. This same Psychiatry Note documents, Review of Symptoms: Mood and Affect- Denies depression, appears calm at the time of exam. Anxiety- Denies anxiety. Thought Content: Denies suicidal ideation. Through Process- No concerns reported. Perception: Denies Hallucinations. Mental Status Evaluation: Behavior- Calm at the time of exam, abrupt with responses. Mood- Calm. Thought Content- No delusion, no suicidal ideation, no homicidal ideation, no paranoia. R2's Physician Orders documents R2 has a Physician Order for Seroquel (antipsychotic) 100mg tablet- take one tablet by mouth one time a day related to Dementia with Other Behavior Disturbance. R2's Care Plan documents R2 receives antipsychotic treatment for Anxiety Disorder, Obsessive Compulsive Disorder, and Behavioral Disturbance related to Major Neurocognitive Disorder. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's (PASRR) Preadmission Screening and Resident Review, dated 1/11/26, documents there are no known mental health behaviors which affect R2's interpersonal interaction or any known mental health symptoms affecting R2's ability to think through or complete tasks which R2 should be physically capable of completing. This same PASRR documents, (R2's) Level I screen does not show that (R2) has a serious mental illness or an IDD (intellectual/developmental disability). (R2) does not need more screening unless (R2) has or may have a serious mental illness or an IDD and experience a significant change in treatment needs. On 4/27/26 from 11:45 AM through 12:05 PM, R2 was sitting at the dining room table with other residents feeding himself. R2 had no behaviors observed throughout this time and ate well. On 4/27/26 at 12:05 PM, V15/Licensed Practical Nurse stated the only behavior she is aware of is R2 can get easily agitated and yell or shove the staff with his walker. V15 stated she has not witnessed R2 being harmful to himself or other residents, or observing R2 to have any psychosis. On 4/27/26 at 12:30 PM, V21/Clinical Care Coordinator confirmed she manages psychotropic medication tracking for the 200 hallways. V21 noted R2 is prescribed Seroquel for Dementia with Behaviors, specifically citing agitation and physical aggression, such as shoving a walker toward staff. However, V21 acknowledged the electronic medical record currently lacks any additional diagnoses to support the medication's use. V21 expressed uncertainty regarding whether Dementia with Behavioral Disturbance alone justifies a Seroquel prescription and confirmed she is unaware of R2 exhibiting psychotic behaviors or having a formal psychosis-related diagnoses. 2. R13's current Physician Order Sheet documents to give Lorazepam (Benzodiazepine/antianxiety) 0.5mg (milligrams), 1 tablet every six hours as needed for Anxiety/Restlessness, initiated 3/25/26. This form documents R13 is to take Lorazepam 0.5mg three times a day, initiated 3/19/26. R13's Progress Notes, dated 2/18/26 at 4:40PM, documents R13 refused all meds besides Lorazepam and Dilaudid (opioid analgesic) this shift and has had poor intake. This form documents R13 is very sleepy today and not easily aroused by physical or verbal stimuli. R13's Progress Notes, dated 2/26/26 at 7:38PM, R13 was sleeping through most of the lunch meal and ate a small amount of food. R13's Progress Notes, dated 3/2/26 at 6:32PM, documents R13 refused her medications. This form documents R13 is very sleepy and refused to open her mouth. R13's Progress Notes, dated 3/3/26 at 8:18PM, documents R13 refused her afternoon medications and med pass supplement, with clenched jaw and refused to open her mouth. This form documents scheduled (pain) medications and Lorazepam were given by a syringe. R13's Progress Notes, dated 3/19/26 at 1:17PM, R13 refused noon medication, was sleepy, and not eating or drinking. On 4/27/26 at 10:00AM, R13 was in her high-back reclining chair, sleeping. At 12:15PM, R13 was in (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the dining room, sleeping on and off in her high-back reclining chair. R13 had to be woken up and assisted with lunch. On 4/29/26 at 12:30PM, R13 was being assisted to her room, sleeping in her high-back reclining chair. At 1:00PM, R13 was in bed sleeping and would not rouse when her name was called out. R13 was observed at various times of the day throughout the survey and did not exhibit any adverse behaviors. On 4/29/26 at 12:20PM, V19, Resident Clinical Care Coordinator, verified she tracks the psychotropic medications and behaviors. V19 stated the only adverse behavior R13 had was grinding her teeth. V19 stated Hospice ordered R13's Lorazepam and was unable to provide a rationale for the continued use of the as-needed Lorazepam past 14 days.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent potential accidents for one resident (R44) with known wandering behaviors of three residents reviewed for incidents and accidents, in a sample of 36. Findings Include: On 4/29/2026, during a continued observation from 10:26AM through 10:40AM., R44 was propelling herself in a wheelchair, in the (facility) 300 hall kitchenette, with no staff present. An unlocked half brown swinging door separated the dining room from the kitchenette. A 3-compartment steam table, located on the counter and accessible to anyone, was turned to the high position. Steam was escaping from around the covered compartments. Upon removal of the lids, boiling water was noted. An accessible radiant warmer, with a Caution Hot warning, was turned on. Upon entrance through the unlocked half door, an open-top three- burner grill was turned on to 300 degrees and an active single deep fat fryer with 390-degree oil was unattended. On 4/29/26 at 10:40AM, V6/Cook entered the 300-hall kitchenette and confirmed the unattended hot appliances and R44's accessibility to the appliances. At that time, V6 stated the cooks for all three of the facility satellite kitchens turn the appliances on around 10:30AM, leave the area to go to their lunch break, and return to serve the meal, which begins at 11:30AM. V6 stated staff turn the appliances on so the food they serve will be hot. On 4/29/26 at 10:45AM, V4/Dietary Manager also verified the hot appliances. V4 stated she was unaware the kitchen staff were turning the appliances on and leaving the area unattended and accessible to any resident. V4 also stated any wandering facility resident could potentially get seriously burned. R44's current Physician Order Sheet, dated April 2026, includes the following diagnoses: dementia, cognitive impairment. R44's current Minimum Data Set Assessment, dated 3/9/26 documents Section C0500 documents R44's cognitive status as cognitively impaired and Section E0900 documents R44 wanders frequently. R44's current Behavioral Progress note, dated 4/23/26 and signed by V12/Behavioral Advanced Practice Nurse documents R44 wanders impulsively. R44's current Care Plan documents R44 has impaired decision making and requires cues/reminders and assistance in order to ensure her needs are met and her safety is maintained. On 4/30/26 at 9:06AM, V3/Executive Director confirmed R44 was cognitively impaired and wandered throughout the facility.		

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NAME OF PROVIDER OR SUPPLIER Snyder Village		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 East Partridge Metamora, IL 61548	
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to address a resident's significant severe weight loss, notify the Dietician, and implement interventions to prevent further weight loss for one of three residents (R50) reviewed for weight loss in the sample of 36. Findings include: The facility's Weight Loss policy, dated 1/27/26, documents, To ensure early identification, evaluation, and intervention for residents experiencing actual or potential weight loss, promoting optimal nutritional status and compliance with regulatory requirements. The facility will monitor resident weights routinely, identify clinically significant weight changes, and implement timely intervention to prevent avoidable weight loss. Clinically significant weight loss: equal or greater than five percent in 30 days, equal or greater than seven and a half percent in 90 days, equal or greater than ten percent in 180 days. This policy also documents Identification of weight loss. Nursing or dining service staff members will review weights weekly. Any significant weight loss triggers: reweigh within 24 hours, initiation of evaluation process. Interventions based on root cause may include (not limited to): dietician consult and revised care plan, nutritional supplements (such as high calorie/ protein), meal assistance or adaptive equipment, appetite stimulants. Update care plan immediately after identification. Include: problem (weight loss risk/actual), measurable goals, individualized interventions. Notify physician of significant weight loss and obtain orders. Notify resident and/or responsible party per facility policy and document. Documentation: record all weights and reweights, assessment findings, interventions, notifications, ongoing monitoring and response. R50's Physician Order sheet, dated 4/28/26, documents R50 was admitted to the facility on [DATE], with diagnoses of Chronic Kidney Disease, Dementia, Muscle Weakness, Anemia, and Vitamin D Deficiency. This order sheet also documents R50 has orders for a regular diet and is to be weighed daily, both started 3/23/26. On 4/27/26 at 11:40 AM, the facility's 100-hall dining room began serving residents' lunch. At this time outside of the dining room in a common area, R50 was seated in a recliner chair with her eyes closed and covered with a blanket. R50's Weight Summary since admission documents R50's admission weight on 3/23/26 was 135.4 pounds. This record also documents on 4/20/26 R50's weight was 122.2 pounds, a 9.75 percent significant weight loss in four weeks. This same weight summary documents R50's weight on 4/27/26 was 113.2 pounds, a 16.4 percent severe significant weight loss in five weeks. R50's Nutrition Note, dated 4/17/26 and completed by V11 (Dietician), documents Initial visit. Weight stable for one month. Goals: maintain weight without significant change. Refer RD (Registered Dietician) PRN (As Needed). R50's electronic medical record does not document any further assessment from a dietician or any nutritional notes after 4/17/26. R50's current Care Plan, dated 3/23/26, does not document a plan of care for R50's nutrition, address R50's weight loss, or document interventions to prevent weight loss. On 4/29/26 at 9:23 AM, V7 (Licensed Practical Nurse/ Care Manager) stated she does see in R50's record where she has triggered for a significant weight loss and R50 does not have a nutritional assessment, aside from the 4/17 visit by V11. V7 stated, (R50) has had significant weight loss. I don't see any Dietician notes since 4/17 in her record, and I am not sure if that visit was in person. We don't really have any flags that alert us with weight loss. I just discover those things when going through the chart and that's how it's recognized. I don't know if the Dietician or a physician was notified about (R50's) weight loss. On 4/29/26 at 11:45 AM, V2 (Director of Nursing) stated V17 (Dietician) comes into the facility to see residents and is available to be contacted as needed. V2 stated, I think she comes a couple times a month, but I am not sure. I don't know who (residents) is on her list to see. On 4/29/26 at 12:10 PM, V11 (Dietician) (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, I just started seeing residents at the facility in March 2026. If there is a concern with a resident's diet or weight I am to be notified by the Dietary manager (V4) or by nursing. I did a note on (R50) for her admission and then I think I was going to do another look at her record today because she is on my list from a couple days ago. V11 confirmed the facility has not notified her of any concerns with R50. V11 stated, I just checked, and I don't have any communications from the facility about (R50) since my last visit. I am supposed to be notified by email if there are weight loss concerns and I do not have any notifications for (R50) specifically.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident's Oxygen administration was documented in the medical record for one of two residents (R5) reviewed for Oxygen in the sample of 36. Findings include: The facility's Oxygen policy, dated 1/27/26, documents, When the unit nurse initiates oxygen therapy for a resident, she must; transcribe the physician's order in the EMAR (Electronic Medication Administration Record). Physician's order should include indication for use. In addition, this record should state the type of respiratory equipment to use. Document in the nurses' notes and EMAR initiation or discontinuation of Oxygen therapy. Monitor and document every shift route and liter flow of oxygen administration and SpO2 (Peripheral Oxygen Saturation) reading. R5's Physician Order sheet, dated 4/28/26, documents R5 was admitted to the facility on [DATE] with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Interstitial Pulmonary Disease, Obstructive Sleep Apnea, Hypertension, Asthma and Atrial Fibrillation. This order sheet documents R5 has an order for Oxygen two to five liters, to keep SpO2 equal to or above 90 percent, with a start date of 3/26/26. R5's Care Plan, dated 3/26/26, documents, (R5) is at risk for complications related to use of Oxygen via nasal cannula at night due to obstructive sleep apnea and refusal of CPAP (Continuous Positive Airway Pressure) use. Interventions: Administer oxygen as ordered by physician. On 4/27/2026 at 10:05 AM, R5 was sitting in bed in his room. R5's bedside contained an Oxygen unit and tubing. R5 confirmed he wears Oxygen when he needs it, which is usually when he is in his room or when he's sleeping. R5's Oxygen Saturation summary, dated 3/26/26 to 4/28/26, documents R5's Oxygen saturation levels were recorded at various times of day on 93 occasions. Out of the 93 Oxygen saturation checks, 36 entries document R5's Oxygen level was taken while on Oxygen via nasal cannula. R5's electronic medical record from admission, including all Medication Administration Records (MAR), Treatment Administration Records (TAR), and Nursing Progress notes, does not document the time that Oxygen administration started, the number of liters per minute administered or the duration of each Oxygen administration that R5 was provided. On 4/29/26 at 9:23 AM, V7 (Licensed Practical Nurse/ Care Manager) confirmed R5's medical record does not document his Oxygen administration times, amount given, or length of Oxygen administration. V7 stated, The Oxygen is not on the MAR, TAR or the task charting for nurses to document the detailed administration. I am not sure why.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident with a diagnosis of hypertension was administered a physician ordered medication to treat high blood pressure and notify the physician of the missed medication administrations for one of ten residents (R50) reviewed for medication administration in the sample of 36. Findings include: The facility's Medication Administration policy, dated 3/23/26, documents, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Administer medication as ordered in accordance with manufacturers specifications. This same policy documents All medication errors will be addressed promptly to ensure resident safety. The nurse will immediately assess the resident, notify the physician and responsible party as indicated, implement any necessary interventions, and monitor for adverse side effects. Incident will be reported to nurse management for appropriate corrective actions, staff education, and system improvements will be implemented to prevent recurrence. R50's Physician Order sheet, dated 4/28/26, documents R50 was admitted to the facility on [DATE], with diagnoses of Dementia, Rheumatic Tricuspid Insufficiency, Hypertensive Chronic Kidney Disease, Hypertension, and Congestive Heart Failure. This order sheet also documents R50 has an order for Nifedipine (anti-hypertensive medication) Extended Release (ER) 60 milligrams (mg), take two tablets (120 mg) by mouth one time daily for Primary Hypertension, start date 3/23/26. R50's Medication Administration Record, dated 4/1/26-4/30/26, documents R50 did not receive Nifedipine ER 120mg on 4/9/26, 4/12/26, or 4/13/26. This record also documents R50's blood pressure reading on 4/12/26 was 180/59 and on 4/13/26 was 177/51. R50's Nursing Progress notes, dated 4/9/26 at 10:10 AM, documents R50's Nifedipine was not administered due to unavailable. R50's Nursing Progress notes, dated 4/12/26 at 8:05 AM, documents R50's Nifedipine was not administered due to Medication unavailable, reordered from pharmacy. Unavailable in STAT safe (pharmacy back-up medication box). R50's Nursing Progress notes, dated 4/13/26, do not document why R50's Nifedipine was not administered. R50's electronic medical record does not document a physician was ever notified of R50 not receiving three scheduled doses of Nifedipine used to treat high blood pressure, or of R50's subsequent elevated blood pressure readings. On 4/29/26 at 12:45 PM, V2 (Director of Nursing) confirmed if a resident's medication is unavailable, the nursing staff should pull the medication from the facility's emergency box and notify the pharmacy. V2 then verified Nifedipine is not available in the emergency medication box and stated, Pharmacy delivers every day except Sunday, and they even make special trips sometimes to deliver medications. I would hope that if that medication was unavailable, the nurse would reach out to the pharmacy and in (R50's) case, with it being for Hypertension, the doctor should be notified.		