STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E701	A. Building B. Wing	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. 35177 Based on interview and record review the facility failed to ensure a facility bed hold policy was in the resident packet of information for a resident who was transferred to the hospital for 1 of 1 resident (R33) reviewed for hospitalization s in the sample of 16. The findings include: The facility' census list for R33, shows on 2/16/25, R33 was transferred out to the hospital. R33's progress noted dated 2/16/25, shows R33 had a change in condition where her oxygen saturations dropped to 86 percent. The nurse practitioner was notified with orders to send to emergency room for evaluation. R33's POA was notified, paperwork was faxed to the hospital. On 2/25/25 at 8:26 AM, V17 (Registered Nurse) stated there is a packet of paper which goes with resident to the hospital, face sheet, POA paperwork, insurance, POLST, meds and diagnoses. We fax the packet to the hospital, and we give the packet to EMS (Emergency Medical Services). V17 was not sure if bed hold went with resident. V1(Administrator) would know. V17 showed this surveyor the packets of information which went with the residents. There was no bed hold policy included in the packets. On 2/25/25 at 11:10 AM, V1 (Administrator) stated the bed hold policy is on a clipboard next to the binders with the resident packets of information. The nurses are to pull one and include. V1 stated she had no evidence to show the bed hold policy was sent with R33 for her emergent transfer to the hospital. V1 stated they used to include in the packet, but the packets were getting too thick, so the bed hold was removed from the resident packets. The facility's Bed Hold Policy and Readmission (undated), shows, in case of emergency transfer, notification of the family or legal representative is provided with written notification within 24 hours of transfer, the resident's copy of the notice is sent with other papers accompanying the resident to the hospital.

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on observation, interview, and record review, the facility failed to provide meaningful activities to dementia residents for 4 of 10 residents (R39, R30, R45, R36) reviewed for activities in the sample of 16. The findings include: 1. R39's Physician Order Sheet (POS) dated 2/25 show R39 has diagnosis of dementia. R39's care plan with review date of 1/21/25 documents, R39 prefers individual 1:1 activities, at times may observe/join a group activity. R39 enjoys walking halls, relaxing in his room, common area, reminiscing, watching TV, visiting with family, listening to music, going outdoors, observing dice/card games, bingo, painting arts and crafts. On 2/23/25, At 10AM, 11AM, 11:37 AM and 12 PM, R39 was up and down the hallways wandering back and forth on both E and F wings in the Dementia Unit. Staff were saying hi to R39. R39 would enter other resident's room, then staff would redirect R39 don't go in that room. R39 was not offered to engage in any activity. R39 had lunch around 12:30 PM. Then at 1PM, 1:30 PM, 2PM and 2:30 PM, R39 continued to wander up and down the hallways. V11 (Registered Nurse/RN) and R39's nurse said this is what he (R39) does all day, walk back and forth aimlessly in the hallways. V11 stated Today is Sunday, we do not offer activities on the weekend. On 2/24/25 at 10AM, 11AM and 12PM, R39 again was up and down the hallway walking back and forth in the Dementia Unit. No staff attempted to engage R39 in any activity including group activities. V9 and V16 (both Certified Nursing Assistant/CNAs) said (R39) gets too tired walking around all day so he wakes up late in the morning then wanders again. 2. R30's activity care plan dated 1/21/25 show, R30 has a diagnosis of dementia and diabetes. R30 needs reminder as to when and where an activity is taking place. R30 enjoys listening to music, Bingo, snack, and chat, observing games, relaxing in room/common area, watching TV, reminiscing, going outdoors, family visits, etc. R30's Activity Interview for daily and activity preferences dated 1/16/25 show, it was important for R30 to get fresh air when the weather is good, and it was important to participate in religious activities. On 2/23/25 at 9:20 AM, 10 AM, and 11 AM, R30 was sitting in a recliner in the common area by the dining room in the Dementia Unit. R30 was just looking around. R30 said hi to this surveyor. At 12PM, R30 was now asleep in his recliner in the common area. There were no ongoing activities. This surveyor asked V14 (CNA) who was in the common area if she was doing any activities with the residents this Sunday. V14 said she was assigned as the Dining room CNA assisting with meals. V14 said she was not an activity aide. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Both V12 and V13 said they were the CNAs on the Dementia unit, (E and F wings) and they were not running activities this Sunday they were working as CNAs. The February Activity Calendar in the Dementia Unit for Sunday 2/23/25 show 1:1 activity. There were no ongoing 1:1 Activity at that time. 3. R45's POS show R45 has diagnoses that include dementia and COPD. R45 wears on oxygen. R45 was alert and able to verbalize his needs. R45's Activity Interview for daily and activity preferences dated 2/6/25 show, it was important for R45 to listen to music, it was important to keep up with the news, it was important to go out for fresh air when the weather is good. On 2/23/25 (Sunday) at 11:45 AM, R45 was in his room watching TV. R45 said there was nothing to do but watch TV in his room. On 2/25/25 at 9:15 AM, R45 said no one comes around and invite him to activities. I would go or just bring me something to do here in my room. On 2/24/25 at 1:14PM, V15 (Activity Director) said she had no Activity Aide to help her. She was the only Activity staff in the Dementia Unit working Monday to Friday. If she was doing group activities, there were no staff providing 1:1 activities. Activities are important to demented residents, it gives them something to do, it keeps them busy. On 2/24/25 at 2PM, V8 (Dementia Care Director) said she will work with V15 to improve the Activity being offered to the dementia resident in the Dementia Unit. V8 said she will discuss with the management regarding Activity Aides on weekends. On 2/24/25 at 3PM V1 (Administrator) said there was a lot for 1 person in the dementia unit to do Activities, we are working on offering activities 7 days a week. 35541 4. R36's current care plan showed R36 was admitted to the secured dementia unit in the facility on 10/29/22 due to his diagnoses of dementia and confusion. The care plan showed R36 enjoyed going outdoors and listening to music. R36's care plan showed, Encourage participation in the following activities, exercise, active games, socials, special events . Assist resident with set up of independent leisure activities as needed . Provide verbal reminders and encouragement to activity programming .Distract (R36) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book . R36's activity assessment dated [DATE] showed it was important for him to listen to music, be around pets, keep up with news, go outside, and do activities with groups of people. On 2/24/25 at 8:59 AM, R36 stood by the locked exit door of the dementia unit. R36 was knocking on the window of the door, saying he wanted to go to the river. On 2/24/25 at 9:01 AM, R36 continued to knock on the window of the exit door of the dementia unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/24/25 at 9:08 AM, R36 was observed walking back and forth by the exit door of the dementia unit. R36 would look out the window of the door and then walk away. On 2/24/25 at 10:08 AM, a staff member was painting the fingernails of a female resident on the dementia unit. Four residents were asleep in the television lounge. Two nonverbal female residents were seated at a table, picking up plastic flowers. R36 paced up and down the hallway of the dementia unit. He would stop at times to look out the window of the exit door of the unit. No staff spoke to R36 and/or attempted to engage R36 in an activity. On 2/24/25 at 10:29 AM, R36 continued to pace up and down the hallway of the dementia unit. R36 walked into the dining area and asked V9 (CNA), What's for lunch today? V9 replied, It's not time yet. R36 shrugged his shoulders and stated, I guess I will go watch TV then. V9 did not respond to R36. V9 made no attempt to engage R36 in an activity and/or ask R36 what he would like to do. On 2/24/25 at 10:37 AM, R36 walked back into the dining area of the dementia unit. R36 asked V9, What time is lunch? V9 stated, 12:30. V9 made no attempt to engage R36 in an activity and/or ask R36 what he would like to do. R36 walked out of the dining area. The facility's Activities policy (undated) showed, The facility will provide a comprehensive activity program designed to promote resident well-being and quality of life, which includes a variety of activities that address physical, cognitive, social, emotional, and spiritual needs. Residents will be given the opportunity to choose activities based on their interests and abilities, and staff will actively encourage participation while respecting resident autonomy to decline activities . Staff responsibilities: Trained staff to lead and facilitate activities. Monitoring resident participation and providing assistance as needed .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34117 Based on observation, interview, and record review the facility to ensure speech therapy recommendations were implemented for a resident with moderate oral/pharyngeal dysphagia. This applies to 1 of 3 residents (R161) reviewed for safety in the sample of 16. The findings include: On 2/23/24 at 12:45 PM, a sign posted on R161's door for droplet/contact precautions. R161 was in her room lying in bed at approximately 30 degrees. R161's noon meal on her bedside table included country fried steak cut up, veggies and mashed potatoes. R161's diet card lists a regular diet. On 2/24/25 at 12:50 PM, R161 was in her room lying in bed at 30 degrees. Her noon meal on her bedside table included a BBQ pork sandwich, corn, and coleslaw. Regular liquids on her bedside table. On 2/24/25 at 12:58 PM, V8 (Licensed Practical Nurse) said R161 has not been doing well, she has influenza and was recently sent out to the hospital and has been declining. She is on a regular diet, has poor appetite and is not aware of R161 having any problems swallowing. On 2/25/25 at 9:54 AM, V1 (Administrator) said speech therapy was here on 2/23/25, she wrote the recommendations and gave it to the director of therapy instead of nursing. The recommendations to downgrade her diet and nectar thick liquids did not get followed through. R161's Physician Order Sheets dated February 2025 shows orders for regular diet. ST evaluation completed .recommend diet downgrade to mechanical soft consistency and nectar thick liquids (order date 2/23/25). R161's Speech Therapy Evaluation and Plan of Treatment report dated 2/23/25 shows new onset of coughing/choking during oral intake (R161) presents with moderate oral/pharyngeal dysphagia . recommendations include mild thick liquids, minced and moist diet and mechanical ground textures. Swallowing strategies including alternate liquid/solid, bolus size modifications and rate modifications, upright during meals, and upright posture for 30 minutes after meals. The facility's undated Management of Dysphagia Policy states, dysphagia, or difficulty swallowing can be caused by various factors and requires appropriate management to prevent complications such as aspiration pneumonia and malnutrition. Dysphagia precautions include dietary guidelines, safe swallowing techniques and staff training.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35177 Based on observation, interview, and record review the facility failed to ensure a resident's adaptive equipment was functioning for 1 of 9 residents (R10) reviewed for restorative in the sample of 16. The findings include: On 02/23/25 at 11:16 AM, R10 was sitting in his wheelchair near the nurse's station. His left arm was dangling next to his side. The wheelchair arm trough attached to the left wheelchair arm was bent over with the bottom of the trough facing away from the resident. R10 stated he does not use it (arm trough) because it was broken. It had been broken for a few months. He told the staff and they said they would fix it, not sure when that is going to happen. R10 explained he had a stroke which affected his left side. R10 then proceeded to self-propel himself using his right foot down the hallway. R10's Facility assessment dated [DATE] shows diagnoses to include stroke and hemiplegia. R10's has impaired range of motion on his left side and is cognitively intact. R10's current care plan shows R10 has impairment on his left arm and left leg. On 02/25/25 at 10:00 AM, V22 (Restorative) stated R10 uses the arm trough for comfort and positioning. V22 was not aware adaptive device was broken. This surveyor went with V22 to R10's room. R10 was lying in his bed and his wheelchair was in the bathroom. R10 stated his arm keeps falling off it (trough). V22 inspected the arm trough and stated the trough was to the side and was not positioned correctly for the resident to use. She looked at the trough further and stated this trough does not go with this wheelchair. I will talk with maintenance and see if there is an arm trough which fits the chair. At 11:05 AM, V22 stated she found an arm trough in the medical supply catalog and will get with maintenance to find one which will fit R10's wheelchair so they can get it ordered. A facility policy on the use and/or care of adaptive equipment was requested. The administrator stated they did not have one.

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F 0744 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. 35541 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 . 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. (continued on next page)

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F 0744 Level of Harm - Actual harm Residents Affected - Few	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 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 . 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 .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 37232 Based on observation, interview, and record review the facility failed to follow the pureed menu for 8 of 8 residents (R1, R2, R7, R11, R13, R18, R33, and R46) reviewed for pureed menu in the sample of 16. The findings include: A facility provided list printed on 2/24/24 showed R1, R2, R7, R11, R18, R33, and R46 were on a pureed diet. The same list showed R13 was on a liquidized pureed diet. The pureed menu for 2/24/25 showed residents on pureed and liquidized pureed diets were to receive pureed BBQ turkey, pureed creamed corn, pureed cornbread, and pureed cake. On 02/24/25 at 10:02 AM, V20 (Cook) was observed making the pureed meal. V20 pureed the BBQ turkey, creamed corn, and dessert. V20 was not observed making pureed corn bread nor was corn bread added to the BBQ turkey or creamed corn. On 02/24/25 at 11:17 AM, V20 started to plate the pureed meal. There was no container of pureed cornbread on the serving steam table. V20 plated R1, R7, R11, and R13's pureed meals by serving them pureed BBQ turkey, pureed creamed corn, and pureed dessert. R1, R7, R11, and R13 did not received pureed cornbread as indicated by the menu. On 02/24/25 at 01:10 PM, R33 was served a room tray. The tray contained a bowl of pureed BBQ meat, a bowl of pureed creamed corn, a bowl of chocolate dessert and four glasses of assorted beverages that were honey thick. There was no pureed corn bread present. On 02/24/25 at 11:50 AM, V21 (Dietary Manager) said the menu should be followed. On 02/25/25 at 09:39 AM, V21 said pureed corn bread was not served.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 34117 Based on observation, interview, and record review the facility failed to ensure staff implemented enhanced barrier precautions to prevent the spread of infection for 2 of 16 residents (R2, R45) reviewed for infection control in the sample of 16. The findings include: 1. On 2/24/25 at 9:22 AM, there was no sign posted on R2's door for enhanced barrier precautions. V24 (Certified Nursing Assistant/CNA) donned gloves and did not wear a gown while providing incontinence care to R2. An open pressure ulcer was observed on R2's coccyx. On 2/24/25 at 2:03 PM, V3 (Assistant Director of Nursing/Infection Control Preventionist) said R2 was on isolation for influenza, and they discontinued her isolation. She said R3 has a wound and should be on enhanced barrier precautions, staff should wear gown and gloves when providing direct care. R2's Physician Order Sheets dated February 2025 does not show orders for enhanced barrier precautions. The P.O.S. shows orders for treatment orders for right coccyx wound. 33760 2. On 02/23/25 at 9:15 AM, R45 was in his room alert and pleasant. An Enhance Barrier Precaution (EBP) sign was posted inside his room. V11 (Registered Nurse/RN) and V12 (CNA) both said R45 has a urinary catheter and uses a leg bag at daytime. R45 pointed to his leg and said yup, it's here. On 2/24/25 at 10:05 AM, R45 was being assisted for his leg bag. V16 (CNA) was wearing gloves but was not wearing any gown. V16 said when R45 woke up this morning, V16 disconnected R45's indwelling urinary bag then connected R45's leg bag. R45 said she had gloves on. On 2/24/25 at 2:20 PM, V17 (RN) confirmed that R45 was on EBP due to his urinary catheter. Staff should use gown and gloves when providing catheter care. R45's Physician Order Sheet (POS) printed on 2/24/25 documents, Enhanced Barrier Precautions r/t indwelling Foley. May be discontinued if Foley is no longer needed. dx: urinary retention The facility Enhance Barrier Precaution undated documents, It is the policy of this facility to implement enhance barrier precautions for the prevention of transmission of multidrug organism targeted by the CDC. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. Clear signage will be posted on the door or wall outside of the resident's room indicating the type of precaution, required PPE and the high-contact resident care activities that require the use of gown and gloves. 4. High contact resident care activities include: a. wound dressing g Device care use: urinary catheters .