Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Illinois Veterans Home – Manteno

Location: One Veterans Drive, Manteno, IL 60950

Onsite / Virtual: Onsite

Dates of Survey: 10/14/25 – 10/17/25

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 304

Census on First Day of Survey: 210

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from October 14, 2025, through October 17, 2025, at the Illinois Veterans Home – Manteno. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43 (b) Drugs and medicines for certain veterans. VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter, subject to the limitation in §51.41(c)(2). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Some	The facility was unable to demonstrate that medications for individuals receiving care at the State home are furnished subject to the limitation in §51.41(c)(2). The findings include: Based on communication with the facility Administrative Staff B, it was identified that the facility has a valid sharing agreement with the VA Medical Center (VAMC) that allows the facility to order most needed drugs and medicines through the VA's Pharmaceutical Prime Vendor (PPV) Contract. The sharing agreement describes that the VAMC will absorb the PPV costs of drugs and medicines for Veterans who are eligible to receive such drugs and medicines and invoice the facility for the costs of drugs and medicines for Veterans who are ineligible to receive such drugs and medicines. Review of documentation for VA-paid drugs and medicines for [DATE] and [DATE] included a list of residents whom the facility identified as being eligible to receive VA-paid drugs and

	medicines based on the resident having a determination of Catastrophic Disability. Further review of those invoices identified that this list included residents for whom the facility received the prevailing rate of VA Per Diem (Prevailing Rate Veterans). Specifically, it was identified that seven (7) Prevailing Rate Veterans in the month of [DATE] and six (6) Prevailing Rate Veterans in the month of [DATE] received VA-paid drugs and medicines. The facility leadership indicated that the facility had not reimbursed the VAMC for any of the costs of these drugs and medicines. Facility leadership confirmed understanding that, in accordance with §51.41(c)(2), the VAMC may not furnish drugs or medicines to Veterans who lack eligibility for such drugs or medicines, including Prevailing Rate Veterans.
§ 51.70 (b) 9 (ii)– (iii) Notification of changes. The facility management must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is— (A) A change in room or roommate assignment as specified in §51.100(f)(2); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. (iii) The facility management must record and periodically update the address and phone number of the resident's legal representative or interested family member. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observation, interview, and record review, the facility failed to notify and consult as required when there were significant changes in the status and treatment of one (1) of one (1) resident reviewed for pressure injuries from a total of 41 residents sampled (Resident #3). Specifically, the facility did not notify the physician and family/representative of a dressing substitution in place of the physician ordered Opticel AG with secondary silicone sacral bandage; observed clinical changes including new wound odor, increased drainage, maceration, and erythema; and documented deterioration in wound measurements. The findings include: The facility's policy titled, "Wound and Skin Management," Section 6.68,reviewed 7/24, required weekly wound assessments with measurements, immediate physician notification when a wound changed, and licensed-nurse completion of weekly evaluations in PCC (Point Click Care – the electronic health record system) with notification to the physician and family/POA (Power of Attorney) when changes occurred. Resident #3 was admitted to the facility on [DATE]. Pertinent medical history included Non-Traumatic Spinal Cord Dysfunction with Paraplegia, Neurogenic Bladder with an Indwelling catheter, and Diabetes Mellitus. The comprehensive Minimum Data Set (MDS), dated [DATE], documented a Stage 4 (Four) pressure injury present on admission with ongoing pressure injury care, nutrition and hydration interventions for skin integrity, and use of a pressure reducing device for the chair. Functionally, Resident #3 used a manual wheelchair and required mechanical lift assistance, and needed supervision to moderate assistance for most self care and mobility tasks.

	Cognitively, the Brief Interview for Mental Status (BIMS) score was 13 of 15, indicating intact cognition. Physician Orders, dated [DATE], required the wound to be flushed with Vashe wound cleanser (a hypochlorous acid solution used to reduce wound bioburden and promote healing), patted dry, covered with Opticel AG (a silver-impregnated gelling fiber dressing providing antimicrobial protection and exudate management), and secured with a secondary silicone sacral bandage. The record contained no documentation that the physician was notified of a substitution of a smaller silicone border dressing, or that a revised order authorized the change. During wound care observation, on 10/16/25, at 9:32 a.m., Licensed Nurse F removed a saturated 4 cm (centimeter) × 4 cm silicone border dressing, revealing a full-thickness sacral pressure injury measuring approximately 5 cm × 3 cm × 0.2 cm with macerated edges, an island of devitalized tissue at the 6 o'clock margin, and peri-wound erythema extending ~2 cm. Licensed Nurse F stated: "It definitely has an odor that wasn't there before." Weekly Wound Notes, from [DATE], through [DATE], were inconsistent/incomplete, with five (5) consecutive weeks missing (weeks ending [DATE]–[DATE]). Measurements reflected decline between [DATE] (4.2 cm × 2.6 cm × 0.1 cm), and [DATE] (5.0 cm × 3.0 cm × 0.2 cm), and deterioration by [DATE] (4.8 cm × 2.8 cm × 0.5 cm with increased drainage and maceration); the record lacked evidence of timely physician or family notification or Plan of Care revision in response to the changes. On 10/16/25, at 3:05 p.m., Licensed Nurse F stated the physician had not been notified of any instances of wound deterioration, nor the increased drainage and odor noted during the 9:32 a.m., dressing change, but would be "contacted today."
§ 51.120 (d) Pressure sores. Based on the comprehensive assessment of a resident, the facility management must ensure that— (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent	Based on observation, interview, and record review, the facility failed to ensure residents received necessary treatment and services to promote healing of existing pressure injuries for one (1) of one (1) resident reviewed for pressure injuries from a total of 41 residents sampled (Resident #3). Specifically, the facility failed to ensure accurate and timely weekly assessments of Resident #3's sacral pressure injury, failed to implement appropriate pressure relief interventions, failed to implement appropriate dressing selection, and failed to revise the Plan of Care and follow through on physician notification when the wound failed to progress, collectively increasing the risk of deterioration and delayed healing. The findings include:

infection and prevent new sores from developing. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Review of the facility policy titled, "Wound and Skin Management," Section 6.68,reviewed 7/24, directed Licensed Nurse F to assess all wounds weekly and PRN (as needed) during rounds, complete weekly wound documentation sheets that describe the wound, measurements, and treatment, and notify the Physician, Administrative Nurse B, and Licensed Nurse F immediately when there appeared to be a change in the condition of a wound. The policy also required licensed nursing staff to complete a weekly wound evaluation in PCC (Point Click Care – electronic medical record) for any resident with a skin alteration and to notify the physician, member, family/POA of the member's condition and document it. Resident #3 was admitted to the facility on [DATE]. Pertinent medical history included Non-Traumatic Spinal Cord Dysfunction with Paraplegia, Neurogenic Bladder with an Indwelling Catheter, and Diabetes Mellitus. The comprehensive Minimum Data Set (MDS), dated [DATE], documented a Stage 4 (Four) pressure injury present on admission with ongoing pressure injury care, nutrition and hydration interventions for skin integrity, and use of a pressure reducing device for the chair. Functionally, Resident #3 used a manual wheelchair and required mechanical lift assistance, needing supervision to moderate assistance for most self care and mobility tasks. Cognitively, the Brief Interview for Mental Status (BIMS) score was 13 of 15, indicating intact cognition. Review of the Physician Orders, dated [DATE], directed nursing staff to flush the sacral wound with Vashe wound cleanser (a hypochlorous acid solution used to reduce wound bioburden and promote healing), pat dry, apply Opticel AG (a silver-impregnated gelling fiber dressing that manages exudate and provides antimicrobial protection), and cover with a secondary silicone sacral bandage. On 10/16/25, at 9:32 a.m., observation of Resident #3 during wound care performed by Licensed Nurse F revealed Resident #3 was initially supine in bed with an alternating pressure mattress in place; the pump was set to a weight of 200 pounds. After positioning on the right side, an undated silicone border dressing sized 4 cm (centimeters) × 4 cm was observed on the sacral area. The dressing was heavily saturated with serosanguinous drainage. The wound margins extended beyond the dressing edges, leaving peri wound tissue exposed. After dressing removal, a full thickness sacral pressure injury measuring approximately 5 cm × 3 cm × 0.2 cm was observed with macerated edges; the wound bed was approximately 75% red granulation tissue with an island of devitalized tissue at the 6 o'clock margin. Erythema extended ~2 cm around the wound. Licensed Nurse F stated: "It definitely has an odor that wasn't

	there before." After cleansing and redressing, Resident #3 was returned to the same position, and Licensed Nurse F left the room. On 10/16/25, at 10:00 a.m., an interview with Resident #3 indicated the resident was not familiar with the current status of the wound or whether it was healing, stating: "They just come in and change it and go." When asked about dressing change frequency, the resident stated: "About every other day or when they get around to it." The resident described the bed as "hard," reported a weight of "about 140 pounds," and stated staff assisted with repositioning "every now and then," clarified as "probably a couple [two] times a day." Subsequent observations of Resident #3's positioning, on 10/16/25, at 11:47 a.m., 1:26 p.m., and 2:49 p.m., revealed the resident had not been repositioned in bed. The alternating pressure mattress pump remained set to 200 pounds. An interview was conducted with Certified Nurse Aide B, on 10/16/25, at 2:50 p.m., regarding the repositioning and care of Resident #13. Certified Nurse Aide B acknowledged that the resident had not been repositioned since the morning wound care procedure, and stated they were "not sure what [the resident's] repositioning schedule is supposed to be." When asked about documentation practices for turning and repositioning, Certified Nurse Aide B explained that staff "usually put everything in at the end of the shift," rather than documenting care when provided. Certified Nurse Aide B confirmed that no repositioning rounds had been performed that afternoon. Continued record review revealed no documentation that the physician was notified of the substitution of a silicone border dressing in place of the ordered Opticel AG with secondary silicone sacral bandage, and no revised order authorizing the change was found. Review of the Plan of Care, last revised on [DATE], directed staff to monitor wound healing weekly by measuring length, width, and depth; document wound bed and peri wound characteristics; monitor for maceration and signs of infection; and report improvements or declines to the physician. Review of Weekly Wound Notes, dated [DATE], through [DATE], revealed inconsistent and incomplete documentation for the sacral Stage 4 pressure injury. Five (5) consecutive weekly assessments, weeks ending [DATE], through [DATE], were missing. Multiple [DATE] and [DATE] entries were late and lacked contemporaneous measurements or drainage

	descriptions. Documented measurements showed reduction in size through late [DATE], followed by deterioration on [DATE], when the wound measured 4.8 cm × 2.8 cm × 0.5 cm, with increased drainage and maceration. Despite this change, the treatment plan remained unchanged, and there was no documentation that the physician, family, or interdisciplinary team was notified. Available measurements demonstrated deterioration in length, width, and depth between [DATE] (4.2 cm × 2.6 cm × 0.1 cm), and [DATE] (5.0 cm × 3.0 cm × 0.2 cm), with increased drainage, maceration, and erythema. There was no evidence of physician notification, wound care consultation, or Plan of Care revision corresponding to these changes. On 10/16/25, at 3:05 p.m., Licensed Nurse F stated the wound had "not really changed much" across weekly assessments and described it as "completely granular," which was inconsistent with the devitalized tissue observed earlier. When asked why a smaller silicone border dressing was used instead of the ordered Opticel AG with secondary silicone sacral bandage, Licensed Nurse F acknowledged the observed dressing was "incorrect," was unsure who applied it, and could not verify whether the ordered products were currently stocked. Licensed Nurse F confirmed the 200 pound mattress setting was not appropriate for Resident #3 (approximately 140 pounds), and reported no specific staff member routinely checked or verified mattress settings. Licensed Nurse F stated the physician had not been notified of any of the instances of wound deterioration, nor the increased drainage and odor noted during the 9:32 a.m., dressing change but would be "contacted today."
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care;	Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure staff administered a Gastrostomy (G) tube water flush by gravity. This affected one (1) of seven (7) residents observed with G-tube medication during medication pass (Resident #33). The findings include: A review of the facility's policy titled, "Nursing Gastrostomy Tubes," with a review date of 7/24, revealed the following: "Procedure: …Gastrostomy-Medication Administration – To ensure the proper and safe administration of medication with a gastrostomy tube…Procedure: …Prepare all medication unless contraindicated by physicians order…Flush tube with 30cc [cubic centimeters] water and put liquid or diluted medication into syringe and let flow by gravity into tube…Flush tube after each medication with [five] 5cc of water and an additional 30cc after last medication is given."

(7) Foot care; and (8) Prostheses. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	A record review of Resident #33's admission record revealed the resident was admitted to the facility on [DATE]. Resident #33 was admitted with the following diagnoses: Gastrostomy and Functional Quadriplegia. A review of Resident #33's clinical record revealed Resident #33 had a gastrostomy tube. An observation, on 10/14/25, at 12:35 p.m., during medication administration, revealed Licensed Nurse D dispensed medications for G-tube administration to Resident #33. Licensed Nurse D pushed 30 cc of water via G-tube to Resident #33 before they administered medications. In an interview, on 10/14/25, at 1:05 p.m., Licensed Nurse D stated they should have administered the water via G-tube by gravity instead, they had pushed the water. In an interview, of 10/17/25, at 9:20 a.m., Administrative Nurse A stated gastrostomy water flushes were to be given by gravity. Administrative Nurse A confirmed that when a water flush was administered by push, this could dislodge the feeding tube.
§ 51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure eye drops were administered correctly to ensure the residents received the ordered dosage of eye medications. This affected one (1) of seven (7) residents observed during medication administration (Resident #40). The findings include: A review of the facility's policy titled, "Medication Administration/Orders," with an effective date of 6/15/16, and updated on 7/2025, revealed the following: "Illinois Veteran's Home at Manteno will develop, implement and maintain policies and procedures to support prescribing and ordering of medications which ensure their safe and appropriate use… Procedure… 24. Instillation of Eye drops…Using finger, pull lower lid down gently and instruct member to look up. Drop medication into the center of lower lid and instruct member to close eyes gently." A record review of Resident #40's Admission Record revealed the resident was admitted to the facility on [DATE]. A record review of Resident #40's current Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #40's Brief Interview for Mental

	Status (BIMS) score was 15, which indicated the resident's cognition was intact. A record review of Resident #40's Physician Order revealed Brimodine Tartrate 2% one (1) drop to both eyes three (3) times a day. An observation, on 10/15/25, at 11:15 a.m., during medication administration, revealed Licensed Nurse A dispensed Brimodine Tartrate 2% for administration. Licensed Nurse A positioned the eye medication dropper over Resident #40's left eye and dropped in one (1) drop of medication. The eye medication dropped onto the resident's upper lash. Licensed Nurse A repeated this process to the right eye, and the medication dropped onto the lower lash and rolled down the resident's cheek. Licensed Nurse A did not readminister the eye medication. In an interview, on 10/15/25, at 11:19 a.m., Licensed Nurse A stated that the eye drops landed onto the resident's upper lash, and the second drop of medication landed onto the resident's lower eyelash. Licensed Nurse A confirmed that the resident did not get the full dose of medication. In an interview, of 10/17/25, at 9:20 a.m., Administrative Nurse A stated when administering eye drops, staff should pull the resident's lower lid downward and place the medication into the resident's lower lid. Administrative Nurse A stated this process ensured the residents got the full dosage of the medication.
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to ensure staff sanitized or washed their hands before applying and after removing gloves, changed gloves after touching contaminated services, did not place contaminated supplies back into a box containing clean supplies, did not place ungloved fingers inside of a crush bag and medication cups and did not touch resident's food with bare hands. This affected three (3) of seven (7) residents observed during medication administration (Resident #33, Resident #38, and Resident #40); one (1) of one (1) resident observed during wound care (Resident #3); and one (1) of 25 sampled residents who staff assisted to peel a banana with bare hands and then fed it to them (Resident #12). The findings include: A review of the facility's policy titled, "Hand Hygiene," with a revised date of 3/19/24, revealed the following: "Procedure… Staff members should perform hand hygiene for the clinical indications listed below…A. When to perform hand hygiene…

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	4. After touching a patient or the patient's immediate environment…6. Immediately after glove removal." 1. A record review of Resident #33's admission record revealed the resident was admitted to the facility on [DATE]. A review of Resident #33's clinical record revealed Resident #33 had a gastrostomy (G)-tube. In an observation, on 10/14/25, at 12:35 p.m., during medication administration, Licensed Nurse D applied gloves and a gown, opened the medication cart, and removed two (2) medications for Resident #33. Licensed Nurse D then obtained a crush bag and placed their left index finger inside the bag to open the crush bag. Licensed Nurse D then placed the first medication into the crush bag and crushed the medication. Licensed Nurse D placed their left index finger inside the bag to open the crush bag, and dispensed the medication into a medication cup and added nine (9) cc (cubic centimeters) of water to the crushed medications. Licensed Nurse D then obtained the second oral medication and opened the crush bag by placing their index finger inside the bag. Licensed Nurse D opened the bag again by placing their index finger inside of the bag to open the bag, and poured the crushed medication into a medication cup. After Licensed Nurse D administered the medication, they removed the dressing from the resident's G-tube site. Licensed Nurse D removed their gloves, removed clean 4 x 4 gauze from the packaging, sprayed saline wash to the 4 x 4s, and removed tape from the medication cart positioned outside of the resident's room. Licensed Nurse D did not wash or sanitize their hands after they removed gloves. In an interview, on 10/14/25, at 1:05 p.m., Licensed Nurse D stated hands should be sanitized before gloves were applied and after gloves were removed, and that was not what they had done. Licensed Nurse D stated fingers should never be placed inside of a crush bag or a medication cup when administering medication. Licensed Nurse D confirmed they did not sanitize their hands after they removed their gloves, and they had placed their fingers inside of the crush bag and the medication cup. Licensed Nurse D also stated these were infection control issues. A record review of Resident #38's admission record revealed the resident was admitted to the facility on [DATE]. A record review of Resident #38's current Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #38 was severely impaired in cognitive skills for daily decision making.

	In an observation, on 10/15/25, at 1:05 p.m., during medication administration, Licensed Nurse E dispensed an oral medication for administration. Licensed Nurse E obtained a crush bag and placed their right thumb inside of the bag to open the bag. Licensed Nurse E placed the medication inside of the crush bag and crushed the medication. Licensed Nurse E placed their right thumb inside of the crush bag and opened the bag, placed the medication in a medication cup with applesauce, and administered the medication to Resident #38. In an interview, on 10/14/25, at 1:08 p.m., Licensed Nurse E stated fingers should never be placed inside of a crush bag to open the bag, but that was what they had done. Licensed Nurse E replied this was an infection control issue. In an interview, on 10/17/25, at 9:20 a.m., Administrative Nurse A stated staff should sanitize or wash their hands before gloves were applied and after they were removed. Administrative Nurse A also stated the inside of a crush bag, or a medication cup, should never be touched. Administrative Nurse A confirmed all of these issues were infection control concerns. 2. On 10/16/25, at 9:45 a.m., an observation of wound care for Resident #3 was conducted. Throughout the procedure, Licensed Nurse F was observed touching multiple wound care supply items, including unopened dressings and a bottle of Vashe wound cleanser, with gloved hands that had been used during the procedure. Licensed Nurse F then returned the unused supplies to the [LOCATION] without cleaning or disinfecting the items or container surfaces. During an interview immediately following the wound care observation, Licensed Nurse F acknowledged returning the unused wound care supplies to the [LOCATION] after handling them during the procedure with contaminated gloves. Licensed Nurse F stated that this was “common" when unopened items were not used. When asked about infection control protocol for supply handling, Licensed Nurse F stated: “If it's not opened, we just put it back.” 3. A review of the facility’s policy titled, “Food Service Sanitation/Storage,” policy number 15.04, dated August 2024, revealed: “Procedure...1. General – Food Protection…6. General Food Preparation and Handling – Pursuant to Section 750.160 a & b: Employees shall avoid direct contact (i.e., using bare hands) with ready-to-eat food whenever possible. Ready-to-eat food shall be handled only with suitable utensils such as deli tissue, spatulas, tongs, or single-use gloves. Thorough hand washing shall precede use of utensils, including deli tissue, spatulas, tongs, or single-use gloves.”

	A review of the medical record for Resident #12 revealed the resident was admitted to the facility on [DATE], with diagnoses that included Vascular Dementia, Lymphocytopenia, Unqualified Visual Loss, Both Eyes, and Unilateral Inguinal Hernia. A review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident had severe cognitive impairment. On 10/15/25, at 10:00 a.m., an observation of Resident #12 revealed they were sitting up in bed awake, alert and oriented to person, place, time, and event (PPTE). They stated to Certified Nurse Aide A that they wanted a snack. Certified Nurse Aide A brought a banana into their room and proceeded to peel the banana using bare hands. Certified Nurse Aide A then pinched off the darkened end with their bare hands and handed the banana to Resident #12. On 10/15/25, at 2:10 p.m., an interview with Certified Nurse Aide A revealed they were unsure why they used their bare hands to peel the banana and pinch off the black end of the banana. They stated they would normally use gloves to prepare the banana. On 10/17/25, at 9:18 a.m., in an interview with Administrative Staff A, they stated they expected staff to use clean, gloved hands to handle bananas when peeling for residents. On 10/17/25, at 10:16 a.m., in an interview with Administrative Nurse A, they stated staff peeling a banana and serving it with bare hands should not be done. They expected staff to use gloves when peeling bananas and touching food. They also expected staff to follow the food handling policy as written.
§ 51.200 (c) Space and equipment. Facility management must— (1) Provide sufficient space and equipment in dining, health services, recreation, and program areas to enable staff to provide residents with needed services as required by these standards and as identified in each resident's plan of care; and (2) Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	Based on observations, interviews, record reviews, and facility policy review, the facility failed to maintain resident wheelchair armrests. A wheelchair armrest was observed to be without a cushion, torn, tattered in appearance, and to have exposed metal prongs. This affected one (1) of one (1) resident observed during tour (Resident #1). The findings Include: A review of the facility's policy titled, "Medical Device Act," dated 9/10, and reviewed 7/24, revealed the following: "Policy: To assure the safety, effectiveness…of medical…devices…Personnel: All Staff Definition of a Medical Devices: A medical device is defined as any instrument, apparatus, or other article that is used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	the body…Medical devices include, but are limited to the following: …Wheel chairs." A record review of Resident #1's Admission Record revealed the resident was admitted to the facility on [DATE]. A record review of Resident #1's current Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed Resident #1's Brief Interview for Mental Status (BIMS) score was 11, which indicated the resident had moderately impaired cognition. A record review of Resident #1's Care Plan revealed the resident had a potential and actual impairment to skin integrity. The intervention documented was to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surfaces. An observation, on 10/14/25, at 12:22 p.m., during the initial tour, revealed Resident #1 was positioned in a wheelchair in their room. The wheelchair's right armrest cushion was missing; the leather covering was partially missing, tattered, and torn; and two (2) metal prongs were exposed. The left armrest leather covering was tattered and torn, and pieces were missing. In an interview, on 10/14/25, at 11:22 a.m., Resident #1 stated the wheelchair's armrest had been in that condition for approximately two (2) months, and staff were aware of it. Resident #1 stated they had no skin tears. The surveyor observed the resident's arms, and no skin injuries were observed. In an interview, on 10/14/25, at 12:30 p.m., Licensed Nurse B observed the resident's wheelchair and stated that the right armrest padding was gone, and two (2) metal prongs were exposed. Licensed Nurse B observed the left armrest and stated the left cushion was worn down, the cushion was exposed, and had jagged edges. Licensed Nurse B confirmed the potential for harm to the resident included puncture wounds or skin injuries to both arms. An observation, on 10/16/25, at 9:20 a.m., of Resident #1's wheelchair revealed no repairs had been made to the wheelchair's armrests. In an interview, on 10/16/25, at 9:23 a.m., Licensed Nurse C stated Resident #1 was assigned to them, but they had never noticed the wheelchair's armrests. Licensed Nurse C observed the resident's wheelchair armrests and stated the right armrest padding was missing, and nails were protruding. Licensed

	Nurse C stated the left armrest covering was tattered and torn. Licensed Nurse C further stated after rounding earlier, they had not noticed the condition of the armrests, but confirmed those areas had the potential for causing skin injuries. In an interview, of 10/16/25, at 9:35 a.m., Licensed Nurse B stated they filed a work order on [DATE], to Social Services (SS). Licensed Nurse B stated SS would send the work order to the department responsible for the repair of the wheelchair armrests. In an interview, on 10/16/25, at 10:00 a.m., Consultant Staff B stated they received the work order on Tuesday, 10/14/25, the day it was sent by Licensed Nurse B. Consultant Staff B stated the order was for the other consultant staff member, and they forwarded the information to the social worker responsible for that group of residents; therefore, they had not done anything with the information regarding the resident's wheelchair. Consultant Staff A stated the consultant staff member who would have received the information was off on [DATE]. Consultant Staff A stated they should have responded to the work order, because they were covering for the consultant staff member who was off on [DATE]. Consultant Staff A confirmed that they had not addressed the work order regarding the resident's wheelchair armrests, and nothing had been done to ensure the resident's wheelchair armrests were repaired or replaced. In an interview, on 10/17/25, at 9:20 a.m., Administrative Nurse A stated tattered and torn armrests with protruding prongs were a safety issue and could cause injury to the residents. Administrative Nurse A confirmed there was no excuse as to why staff had not followed through on the work order and repaired the resident's wheelchair.
§ 51.210 (h) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility	Based on interview and record review, the facility's management failed to obtain a sharing agreement that governed mental health services provided to eight (8) residents of eight (8) residents receiving mental health services by the Veterans Administration Medical Center (VAMC) (Residents #20, # 21, #22, #23, #24, #25, #26, and #27). The findings include: Review of the facility's contracts for the annual survey revealed they did not have a contract for mental health services provided to eight (8) residents who were receiving services from the VAMC or the Community Based Outpatient Clinics through the VAMC.

management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** –Many	During an interview, on 10/16/25, at 9:37 a.m., Administrative Staff A stated they did not have a sharing agreement for mental health services provided by Hines Veterans Administration Mental Health Clinic, Jesse Brown Veterans Administration Mental Health, or Joliet CBOC (Community Based Outpatient Clinic) Mental Health Clinic, which were all under the VAMC's administration. Administrative Staff A stated it was important to have a sharing agreement because it defined the responsibility of the care and services provided to the residents, as well as the responsibilities of the veteran's home.