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 60905

Onsite / Virtual: Onsite

Dates of Survey: 09/24/24 – 09/27/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 304

Census on First Day of Survey: 222

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from September 24, 2024, through September 27, 2024, 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.
§ 51.40 (a) Basic rate. Except as provided in §51.41, VA will pay per diem for care provided to an eligible veteran at a State home at the lesser of the following rates: (1) One-half of the daily cost of the care for each day the veteran is in the State home, as calculated under paragraph (b) of this section. (2) The basic per diem rate for each day the veteran is in the State home. The basic per diem rate is established by VA for each fiscal year in accordance with 38 U.S.C. 1741(a) and (c). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The facility was unable to demonstrate that the correct basic rate of per diem was paid for care provided to an eligible Resident at a State home. The findings include: Based on communication and record reviews, it was identified the facility did not claim the correct per diem rate in accordance with § 51.41 for 7/2024 which allowed the facility to claim the full basic per diem rate of $138.29 instead of the correct per diem rate of $86.52. Resulting in an overpayment of $279,765.08.

§ 51.41 (c) (2) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under this paragraph (c) includes payment for drugs and medicines). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The facility was unable to demonstrate that no individual, insurer, or entity was charged for the nursing home care paid for by VA under a VA provider agreement for services rendered by community providers for prevailing rate Veterans. The findings include: Based on communications and record reviews, it was identified that the facility utilizes third-party providers for podiatry, radiology and other diagnostic services, and dental services. Upon review of the written agreements between the facility and the third-party providers, it was identified that insurance was billed for services for Residents for whom the facility receives the prevailing rate of VA Per Diem for nursing home care. The third-party vendor billed prevailing rate Residents insurance from 9/2023 to 6/2024 for podiatry and radiology and other diagnostic services. Upon review of the written agreements, it was identified that the facility does not currently have any responsibility towards payment of routine and emergency dental services for Residents for whom the facility receives the prevailing rate of VA Per Diem for nursing home care. The facility leadership could not provide evidence to demonstrate that the facility had paid the costs for Prevailing Rate Veterans in receipt of podiatry, radiology and other diagnostic services, and dental services and no individual, insurer, or entity was charged for nursing home care.
§ 51.70 (c) (5) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility management must convey within 90 calendar days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate; or other appropriate individual or entity, if State law allows. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Some	Based on record review, the facility failed to ensure, upon the death of a resident with personal funds deposited with the facility, to convey those funds within 90 calendar days and supply a final accounting of those funds, to the appropriate individual or entity for twelve Residents. The findings include: Per review of records, it was identified twelve deceased Residents have remaining personal funds deposited with the facility. The funds have not been conveyed within 90 calendar days. Dates of discharge are listed as 10/8/2022, 3/12/2023, 7/13/2023, 7/14/2023, 8/23/2023, 9/8/2023, 9/19/2023, 1/11/2024, 4/14/2024, 4/22/2024, 5/7/2024, and 6/26/2024.
§ 51.90 (a) (1) – (4) Restraints. (1) The resident has a right to be free from any chemical or physical restraints imposed for purposes of discipline or convenience. When a restraint is	Based on observations, interviews, record review, and review of facility policy, the facility staff failed to protect a resident's right to be free from physical restraints by placing a resident in a chair that prevented the resident from rising independently. This deficient practice affected two (2) of two (2) residents

applied or used, the purpose of the restraint is reviewed and is justified as a therapeutic intervention. (i) Chemical restraint is the inappropriate use of a sedating psychotropic drug to manage or control behavior. (ii) Physical restraint is any method of physically restricting a person's freedom of movement, physical activity or normal access to his or her body. Bed rails and vest restraints are examples of physical restraints. (2) The facility management uses a system to achieve a restraint-free environment. (3) The facility management collects data about the use of restraints. (4) When alternatives to the use of restraint are ineffective, a restraint must be safely and appropriately used. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	reviewed for physical restraints from a total of 37 residents sampled (Resident #2 and Resident #37). The findings include: A review of Resident #2's medical record revealed an original admission date of [DATE]. Their medical history included Neurocognitive Disorder with Lewy Bodies and Parkinson's Disease. On 9/25/24, at 11:10 a.m., Resident #2 was observed in a reclining Broda chair. The chair was positioned in front of a television in the [LOCATION]. The television was on. The back of the chair was reclined, and the leg supports were extended outward, effectively placing Resident #2 in a supine (flat) position where they were unable to see the television. A neck pillow was observed laying on the floor next to Resident #2's chair. Resident #2 was grasping the left armrest with their left hand and the right armrest with their right hand attempting to pull themselves up from the supine position. Resident #2's position in the wheelchair prevented them from rising independently to a sitting position. When asked whether they were comfortable, Resident #2 stated, "No! I'm trying to sit up." Additional interview questions were attempted with Resident #2, but they were not able to answer due to impaired cognition. On 9/25/24, at approximately 11:20 a.m., Administrative Nurse B entered the [LOCATION], picked up the neck pillow from the floor, and placed it behind Resident #2's neck. Administrative Nurse B then asked Resident #2 to lay back in their chair. Resident #2 complied and returned to the supine position. Resident #2 was still unable to see the television. Immediately after Administrative Nurse B left the [LOCATION], Resident #2 again intermittently began attempting to raise themselves from the chair. On 9/25/24, at 12:10 p.m., Resident #2 was observed in the Broda Chair attempting to raise themselves up from a reclined position. Resident #2 repeatedly yelled, "Hello!" No staff responded. Continued review of Resident #2's medical record revealed a focus area in the resident's Plan of Care for limited physical mobility. The focus area indicated that Resident #2 utilized a Broda Tilt for "mobility, comfort, and repositioning." An intervention, dated [DATE], indicated that a seating evaluation by Consultant Staff B had been conducted, and that recommendations were made to continue use of the Broda Tilt chair for "mobility, comfort, and repositioning."

	On 9/26/24, at 12:44 p.m., an interview was conducted with Administrative Nurse B regarding Resident #2's positioning and mobility. When asked about facility staff's decision to place the resident in a reclining Broda chair, Administrative Nurse B stated, "We [facility staff] put [them] in it because [they weren't] able to propel himself in a regular wheelchair anymore." When asked if a Broda Chair reclined to a completely supine position was the least restrictive transition from a manual wheelchair, Administrative Nurse B stated, "Well, no, probably not." Administrative Nurse B was not able to recall when the Broda chair was first used by Resident #2. Administrative Nurse B was also unable to recall whether any other measures were attempted prior to placing Resident #2 in the Broda chair. When asked whether Resident #2's condition required them to be completely reclined in the Broda chair, Administrative Nurse B stated, "We'll have to look at that." Administrative Nurse B then added that Resident #2's family sometimes came to get them for outings, and that the resident "can use a regular wheelchair during outings because the family is able to provide 'one on one supervision'." When asked to clarify whether facility staff were utilizing the Broda chair as a substitute for supervision of Resident #2, Administrative Nurse B shrugged their shoulders and did not answer the question. On 9/26/24, at 2:06 p.m., an interview was conducted with Consultant Staff B and Consultant Staff C. When asked what assessment or protocol facility staff used to determine that the Broda chair in a supine position was appropriate for Resident #2, Consultant Staff B stated, "It has always been my goal to get [them] into a regular, manual wheelchair. I think that would definitely improve [their] mobility." Consultant Staff B went on to explain that Resident #2 was already in the Broda Tilt chair when they started working at the facility. Consultant Staff B was then asked whether Resident #2 had been assessed for a less restrictive chair. Consultant Staff B explained that Resident #2 had last been assessed by them in [DATE], but that "we didn't look at the chair." When asked why a resident's chair would not be evaluated as part of a comprehensive occupational therapy screening, Consultant Staff B could not explain. A restraint policy was requested from Administrative Staff A on 9/26/24, at 4:17 p.m. A communication from Administrative Staff A was received and it read, "The Veterans' Home is a restraint-free home; therefore, there is no policy related to restraints." Record review of Resident #37's Face Sheet revealed they were admitted to the facility on [DATE], with the following diagnoses: Parkinson's Disease without Dyskinesia, Depression, Hypertension, and Chronic Kidney Disease Stage three (3).

	Record review of Resident #37's Minimum Data Set (MDS), dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of six (6), which indicated severe cognitive impairment. Further review of the MDS revealed that Resident #37's Functional Abilities and Goals were documented as not having an impairment with their upper extremity (shoulder, elbow, wrist, hand), nor their lower extremity (hip, ankle, knee, foot). Record review of Resident #37's "Nursing Admission/Readmit Screener" document, dated [DATE], revealed they were admitted from another facility and arrived in a wheelchair. Comments reviewed under Range of Motion (ROM)/Motor Control section read that Resident #37 was assessed to be able to move all extremities. Record review of a Restorative Evaluation document, dated [DATE], for Resident #37's bed mobility, revealed: "Call received from [LOCATION], member was leaning in wheelchair severely to the right and they [staff] were afraid that member would fall out of chair. Unable to sit up straight. Took extensive to dependent assistance by [two] 2 staff to transfer from wheelchair to Broda tilt. Is alert to person. Needs will be anticipated by staff. Passive Range of Motion (PROM) to all extremities Within Normal Limits (WNL), joints very stiff." Record review of a Restorative Evaluation dated [DATE], for Resident #37 revealed their last occupational assessment was conducted on [DATE]; their physical therapy assessment was conducted on [DATE]; and a speech/language assessment was conducted on [DATE]. Record review of an initial Activity Evaluation document, dated [DATE], for Resident #37 revealed: "is new to the facility, appeared confused at times but able to answer yes and no questions directed toward them. Has a Broda tilt wheelchair and will be provided with an escort to and from activities." Record review of Resident #37's Care Plan, with an initiation date of [DATE], revealed a focus area of: "Limited physical mobility related to Parkinson's…the goal is [they] will remain free from complications related to immobility." Intervention/Tasks included: "requires dependent assistance by one (1) staff for locomotion using Broda tilt." Record review of Resident #37's electronic medical record did not provide physical/occupational therapy assessments to determine if a Broda was an ergonomic fit for them.

	Observation, on 9/24/24, at 12:31 p.m., revealed Resident #37 was sitting in a Broda chair in the [LOCATION] swaying their upper body back and forth. During an interview, on 9/24/24, at 12:35 p.m., Resident #37 stated they were admitted in early [DATE]. They stated they would like to receive more therapy so they could use a regular wheelchair to push themselves throughout the facility. They stated that before they were admitted, they always used a regular wheelchair without any problems. When the surveyor asked why they were now in a Broda chair, they stated the facility said it was a "better fit for [them]." They also stated they felt "stuck" and "trapped" in the Broda chair because they must wait for staff to push them throughout the facility, and they would prefer to move themselves wherever they wanted to go. In an interview with Consultant Staff C and Consultant Staff B, on 9/25/24, at 2:30 p.m., they both stated that they did not have medical records or access to any therapy assessments for Resident #37 because a new therapy contract took over in [DATE] and they were admitted in [DATE]. In a follow-up interview, on 9/26/24, at 12:30 p.m., Resident #37 was observed in the [LOCATION] sitting watching television with four (4) other residents. Resident #37 agreed to another interview, and the surveyor requested that staff push them to a private area. Resident #37 recalled the surveyor visiting with them previously concerning their Broda chair. Resident #37 stated staff were not readily available to move them when they wanted to move to different parts of the facility, and they had never used a Broda prior to facility admission, did not feel safe because they felt stuck in the Broda chair. Resident #37 also stated that they had talked to the head of the therapy department and was told a new wheelchair would take two (2) to three (3) weeks to get, but they had been waiting a long time; way over four (4) weeks, and it was an inconvenience for them to sit and wait. During an interview, on 9/26/24, at 1:35 p.m., Administrative Staff A confirmed a new therapy contract did take over the therapy department, and if they were to request existing records, there was no guarantee the surveyor would have received them. Administrative Staff A further stated they did not have access to those medical records. In a follow up interview with Consultant Staff C and Consultant Staff B, on 9/26/24, at 2:05 p.m., they both stated Resident #37 was initially assessed for a Broda chair, and they had always used a Broda chair since being admitted to the facility. When Consultant Staff C was asked how they determined if Resident #37 was a proper fit for a Broda chair, they replied, "I'm not

	saying [they were] a fit for the Broda; the restorative nurse established they were a fit for the Broda chair, and our goal was to get them out of the Broda chair." Consultant Staff C further stated they tried to put Resident #37 in a manual wheelchair, and they self-propelled 40 feet, but was not consistent because they took two (2) breaks. In addition, Consultant Staff C stated that Resident #37 told them they did not feel safe in the Broda chair. When the surveyor asked Consultant Staff C how they responded to Resident #37's concern, they stated the Broda chair was appropriate, and they were there to make recommendations.
§ 51.90 (b) (1) – (5) Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. (1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation. (2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment. (3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. (4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. (5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	Based on observations, interviews, and record review, the facility failed to provide the necessary care and services to prevent harm by placing a cognitively impaired resident in an unsafe and unsupervised condition resulting in a fall with major injury. This deficient practice affected one (1) of one (1) resident reviewed for elopement from a total of 37 residents sampled (Resident #3). The findings include: A review of Resident #3's medical record revealed an original admission date of [DATE]. Their medical history included Dementia with Behavioral Disturbances. A Significant Change Minimum Data Set (MDS) Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of four (4) out of a possible 15 points, indicating severely impaired cognition. The assessment also identified Resident #3 as having wandering behaviors, and that they had sustained a fall with a major injury. A preliminary review of Resident #3's Plan of Care revealed a focus area for wandering and elopement. The focus area described Resident #3 as having eloped from the facility on [DATE]. A preliminary review of Resident #3's Physician Orders revealed an order, dated [DATE], to transfer Resident #3 to the hospital for evaluation after sustaining a fall. A review of the facility's investigative report for Resident #3's elopement was conducted. The report indicated that, on [DATE], Resident #3 was assisted from a ditch located off facility grounds by passers-by and was returned to the facility by them. According to the report, at the time of the elopement, Resident #3 was housed in the facility's [LOCATION], which was equipped with doors that required a code to open. The report failed to identify the circumstances under which Resident #3 was able to exit the [LOCATION], exit the facility, and walk

	several hundred yards off the facility's grounds, where they were ultimately discovered in a ditch by passers-by. A review of Resident #3's Progress Notes revealed an entry, dated [DATE], at 3:38 p.m., by Licensed Nurse A which indicated that Licensed Nurse A received a call from [staff] at 1:40 p.m., on [DATE], telling them that Resident #3 had been assisted back to the facility after being discovered in a ditch. At that time, Licensed Nurse A responded and assessed Resident #3, who was unable to describe the circumstances of the event. Resident #3 was noted to have discoloration to their right eyelid, to their cheek, an abrasion on their nose, and discoloration to their right wrist and arm. Resident #3 complained of pain to the left side of their neck. Resident #3's vital signs were not assessed, and Licensed Nurse A documented that there was "no equipment to take VS [vital signs]." Resident #3 was transferred to the hospital following Licensed Nurse A's assessment. A Progress Note, dated [DATE], at 6:25 p.m., by Licensed Nurse A described Resident #3 as returning from the hospital via a stretcher and assisted by paramedics. The note indicated a CT [computerized tomography] scan of the brain, cervical spine, and facial bones was conducted and the results were negative. The note did not describe any actions taken to determine how Resident #3 left the facility unattended, and did not describe any additional interventions taken to increase Resident #3's level of supervision. Continued review of Resident #3's Progress Notes revealed an entry, dated [DATE], at 10:51 a.m., by Licensed Nurse A, which indicated that Resident #3 stated they "jumped into the ditch to get out of the way of a car." Purple bruising was noted to Resident #3's right eye. Review of a Medication Review by Consultant Staff D, dated [DATE], at 2:49 p.m., read: "Member somehow escaped from the [LOCATION] and had fallen. [They were] assessed in the [LOCATION] of [LOCATION]. [They had] moderate cognitive decline and could not recall how [they] got out of the [LOCATION] or how [they] fell. [They] had discoloration from [their] right eyelid to [their] cheek, an abrasion which was red and swollen on [their] nose, and discoloration to [their] right lower arm and wrist." Review of a Progress Note, dated [DATE], at 11:34 a.m., by Licensed Nurse B indicated that Licensed Nurse B was notified by Consultant Staff A that Resident #3 complained of pain to their right ribs on [DATE]. On assessment, Resident #3 complained of discomfort to their right rib cage with "gentle

	pressure." Licensed Nurse B requested that Resident #3 be assessed by the Medical Provider. Review of a Progress Note by the Medical Provider, dated [DATE], at 12:00 p.m., described Resident #3 as eloping from the [LOCATION] and falling into a ditch outside of the facility. Resident #3 subsequently complained of right-sided rib cage pain with movement and deep breathing. A rib series x-ray was subsequently ordered. Review of a Progress Note, dated [DATE], at 9:39 a.m., revealed the x-ray report was received, which identified two (2) fractures to Resident #3's right ribs. Review of a Progress Note by Consultant Staff A, dated [DATE], at 10:23 a.m., revealed that they spoke with Resident #3's family member and reported the rib fractures. According to the note, a discussion was held with the family member regarding Resident #3's elopement. The note read, "Explained to [them] that we do not have an exact point where [Resident #3] was able to get out of the door." On 9/26/24, at 12:27 p.m., an observation of Resident #3 was conducted in the [LOCATION]. They were observed in their bed with their eyes closed. The door to the [LOCATION] was noted to be locked and required a code to enter. A camera was noted to be pointed at the door. However, according to Administrative Staff A, the camera was not functional. On 9/26/24, at 12:35 p.m., an interview was conducted with the [LOCATION] Administrative Nurse A. They confirmed that Resident #3 was independently ambulatory and confirmed that Resident #3 presented with wandering behaviors and required secure memory care services. Administrative Nurse A also explained that facility staff were "not really sure" how Resident #3 was able to exit the facility unsupervised and were unsure of any additional actions taken to address the circumstances of the elopement. On 9/26/24, at 2:05 p.m., an interview was conducted with Administrative Staff A regarding Resident #3's elopement. After reviewing the investigative report with Administrative Staff A, they confirmed that the report focused on Resident #3's injuries rather than determining the root cause of the elopement. Administrative Staff A explained that the facility was unsure how Resident #3 left the facility unsupervised, and that there were possible scenarios, such as Resident #3 trailing behind a staff member who was exiting the [LOCATION].

§ 51.90 (c) (3) Staff treatment of residents. The facility management must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interviews and record review, the facility failed to thoroughly investigate an event where facility staff failed to provide the necessary care and services to prevent harm by placing a cognitively impaired resident in an unsafe and unsupervised condition resulting in a fall with major injury. This deficient practice affected one (1) of one (1) resident reviewed for elopement from a total of 37 residents sampled (Resident #3). The findings include: A review of Resident #3's medical record revealed an original admission date of [DATE]. Their medical history included Dementia with Behavioral Disturbances. A Significant Change Minimum Data Set (MDS) Assessment, dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of four (4) out of a possible 15 points, indicating severely impaired cognition. The assessment also identified Resident #3 as having wandering behaviors, and as having sustained a fall with a major injury. A preliminary review of Resident #3's Plan of Care revealed a focus area for wandering and elopement. The focus area described Resident #3 as having eloped from the facility on [DATE]. A preliminary review of Resident #3's Physician Orders revealed an order, dated [DATE], to transfer Resident #3 to the hospital for evaluation after sustaining a fall. A review of the facility's investigative report for Resident #3's elopement was conducted. The report indicated that, on [DATE], Resident #3 was assisted from a ditch located off facility grounds by passers-by and was returned to the facility by them. According to the report, at the time of the elopement, Resident #3 was housed in the facility's [LOCATION], which was equipped with doors that required a code to open. The report failed to identify the circumstances under which Resident #3 was able to exit the [LOCATION], exit the facility, and walk several hundred yards off the facility's grounds, where they were ultimately discovered in a ditch by passers-by. A review of Resident #3's Progress Notes revealed an entry, dated [DATE], at 3:38 p.m., by Licensed Nurse A, which indicated that Licensed Nurse A received a call from [staff] at 1:40 p.m., on [DATE], telling them that Resident #3 had been assisted back to the facility after being discovered in a ditch. At that time, Licensed Nurse A responded and assessed Resident #3, who was unable to describe the circumstances of the event. Resident #3 was noted to have discoloration to their right eyelid, to their cheek, an abrasion on their nose, and discoloration to

	their right wrist and arm. Resident #3 complained of pain to the left side of their neck. Resident #3's vital signs were not assessed, and Licensed Nurse A documented that there was "no equipment to take VS [vital signs]." Resident #3 was transferred to the hospital following Licensed Nurse A's assessment. A Progress Note, dated [DATE], at 6:25 p.m., by Licensed Nurse A described Resident #3 as returning from the hospital via a stretcher and assisted by paramedics. The note indicated a CT [computerized tomography] scan of the brain, cervical spine, and facial bones was conducted and the results were negative. The note did not describe any actions taken to determine how Resident #3 left the facility unattended, and did not describe any additional interventions taken to increase Resident #3's level of supervision. Continued review of Resident #3's Progress Notes revealed an entry, dated [DATE], at 10:51 a.m., by Licensed Nurse A, which indicated that Resident #3 stated they "jumped into the ditch to get out of the way of a car." Purple bruising was noted to Resident #3's right eye. Review of a Medication Review by Consultant Staff D dated [DATE], at 2:49 p.m., read: "Member somehow escaped for the [LOCATION] and had fallen. [They were] assessed in the [LOCATION] of [LOCATION]. [They had] moderate cognitive decline and could not recall how [they] got out of the [LOCATION] or how [they] fell. [They] had discoloration from [their] right eyelid to [their] cheek, an abrasion which was red and swollen on [their] nose, and discoloration to [their] right lower arm and wrist." Review of a Progress Note dated [DATE], at 11:34 a.m., by Licensed Nurse B indicated that Licensed Nurse B was notified by Consultant Staff A that Resident #3 complained of pain to their right ribs on [DATE]. On assessment, Resident #3 complained of discomfort to their right rib cage with "gentle pressure." Licensed Nurse B requested that Resident #3 be assessed by the Medical Provider. Review of a Progress Note by the Medical Provider dated [DATE], at 12:00 p.m., described Resident #3 as eloping from the [LOCATION] and falling into a ditch outside of the facility. Resident #3 subsequently complained of right-sided rib cage pain with movement and deep breathing. A rib series x-ray was subsequently ordered. Review of a Progress Note dated [DATE], at 9:39 a.m., revealed the x-ray report was received, which identified two (2) fractures to Resident #3's right ribs.

	Review of a Progress Note by Consultant Staff A, dated [DATE], at 10:23 a.m., revealed that they spoke with Resident #3's family member and reported the rib fractures. According to the note, a discussion was held with the family member regarding Resident #3's elopement. The note read: "Explained to [them] that we do not have an exact point where [Resident #3] was able to get out of the door." On 9/26/24, at 12:27 p.m., an observation of Resident #3 was conducted on the [LOCATION]. They were observed in their bed with their eyes closed. The door to the [LOCATION] was noted to be locked and required a code to enter. A camera was noted to be pointed at the door. However, according to Administrative Staff A, the camera was not functional. On 9/26/24, at 12:35 p.m., an interview was conducted with the [LOCATION] Administrative Nurse A. They confirmed that Resident #3 was independently ambulatory and confirmed that Resident #3 presented with wandering behaviors and required secure memory care services. Administrative Nurse A also explained that facility staff were "not really sure" how Resident #3 was able to exit the facility unsupervised and were unsure of any additional actions taken to address the circumstances of the elopement. On 9/26/24, at 2:05 p.m., an interview was conducted with Administrative Staff A regarding Resident #3's elopement. After reviewing the investigative report with Administrative Staff A, they confirmed that the report focused on Resident #3's injuries rather than determining the root cause of the elopement. Administrative Staff A explained that the facility was unsure how Resident #3 left the facility unsupervised, and that there were possible scenarios, such as Resident #3 trailing behind a staff member that was exiting the [LOCATION].
§ 51.100 (a) Dignity. (a) Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, interview, record review, and facility policy review, the facility failed to promote treatment of residents with respect and dignity while assisting them with eating their lunch meal. Specifically, the facility failed to ensure staff assisted residents without standing over them while providing eating assistance for three (3) of 16 residents observed in the [LOCATION]. The findings include: Record review of the facility policy titled, "Member Rights," dated as Reviewed/Revised July of 2024, revealed: "It is the philosophy and policy of the [facility] to treat all members in the least restrictive and most dignified manner possible. All staff are to ensure that all members are treated equally and fairly."

	Observation of the [LOCATION] during the lunch meal, on 9/24/24, at 12:55 p.m., revealed Licensed Nurse D, Certified Nurse Aide A, and Certified Nurse Aide B standing over three Residents and assisting them with their meal, while the residents were sitting at the dining table. Observation in the [LOCATION] during the lunch meal, on 9/24/24, at 1:02 p.m., revealed Administrative Nurse C had pushed chairs towards Licensed Nurse D, Certified Nurse Aide A, and Certified Nurse Aide B, and told them each to sit down while assisting the residents with eating their meal. In an interview with Administrative Nurse C, on 9/25/24, at 2:40 p.m., they stated staff knew better than to stand over residents while assisting with eating meals. They stated their expectations were for staff to sit at eye level next to the resident(s), be attentive to the resident, and care for them in a manner that promoted their dignity. A meal assistance policy was requested from Administrative Staff A on 9/26/24, at 4:17 p.m.; however, a policy was not provided. Administrative Staff A provided an annual training list of classes for direct care staff, which covered their dining experience, which was identified as #32 on the training list. In addition, Administrative Staff A provided a printout of a document titled, “Dining Experience Person-Directed Dining,” which revealed: “dignity and personal needs and wants are always considered in person-directed dining.”
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation, interview, record review, and facility policy review, the facility failed to ensure foods were stored, prepared, distributed, and served under sanitary conditions as evidenced by 1.) failure to ensure the dish machine and refrigeration temperatures were consistently monitored and documented; 2.) failure to ensure food preparation equipment was cleaned after each use; and 3.) failure to ensure foods brought into the facility by residents and family members were dated and labeled. These failures put all residents at risk for food borne illnesses. The findings include: When asked for a [LOCATION] sanitation policy, the surveyor was provided with two (2) pages of documentation noted to be pages 4 and 5, which revealed under subheading 5, a policy titled, “Monitoring and Quality Control – Temperature Control; Regularly monitor and record the temperatures of refrigerators.” A policy on the storage of food brought (purchased) by families or residents was requested, but only a typed written note was

	provided that stated: "The Illinois Veterans Home at Manteno (IVHM) does not have a policy related to members' families or members bringing food into facility." Review of two (2) other facility policies provided, which were both titled "Nursing Procedure," and dated reviewed 6/23/24, revealed only a reference which indicated that the residents' refrigerator temperature checks would be a duty to be completed by the assigned nurse on the 11:00 p.m., to 7:00 a.m., shifts. No other reference regarding food stored in the refrigerators was provided or found within the document provided. In addition, there was no information found about who cleaned the refrigerators or ensured the food located in them was not spoiled or outdated. 1. On 9/24/24, at 10:17 a.m., during the initial [LOCATION] tour with Dietary Staff A, Dietary Staff C was observed assisting other staff cleaning in the dishwashing area. When asked, the staff provided the "High Temperature Dishmachine Temperature Log." Although the log had sections that were available to document temperatures for the dish machine for each meal for seven (7) days, it only had one temperature logged on it for four (4) of the seven (7) days reviewed. Additional dates had been written on the bottom of the log, and read: "9/16, 9/19, 9/20." All were indicated for 2024; however, the only day a temperature was recorded for all meals provided was on the 9/16/24 entry. The other dates of 9/19/24, and 9/20/24, only recorded one temperature on each day, and no record of the temperatures was logged for 9/17/24, or 9/18/24. During an interview with Dietary Staff A, on 9/24/24, at 10:19 a.m., they acknowledged the log was incomplete, and further commented the temperatures should have been monitored and documented on the log for each meal. Observation, on 9/24/24, between 10:20 a.m., and 10:30 a.m., during the [LOCATION] tour revealed that the walk-in refrigerator in the [LOCATION] had a temperature log attached to it. The log directed staff to document two (2) daily temperatures; one in the a.m., (morning), and another in the p.m., (evening). The log also had dates missing for where the temperatures should have been checked and noted. Additional review of refrigerator logs maintained for June, July, and August of 2024, for the dairy, produce, bakers, cooks, and starter refrigerators also had missing temperatures on the log. A review of the temperature logs for the "Starter" refrigerator showed the temperatures logged were reading in the danger zone (above 41 Degree ºF) between the dates of 6/1/24, and 6/10/24; and between the dates of 6/22/24, and 6/26/24. Further review revealed that on 7/3/24, the temperature log

	revealed all items (foods) were removed, and a work order was completed for the repairs needed, which were finished on 7/9/24. On 9/26/24, at 1:00 p.m., Dietary Staff B was interviewed about the refrigerator temperature logs, and they acknowledged they were incomplete. When asked about the temperatures recorded for the "Starter Refrigerator" during the month of June 2024, they stated they were only using that refrigerator for the tray line, and everything [referring to foods] was removed from that refrigerator after meals were served. Dietary Staff B further explained that the refrigerator was taken out of service and was repaired in July 2024, and stated it was no longer experiencing problems with holding the correct temperatures. 2. Observation, on 9/24/24, between 9:30 a.m., and 9:35 a.m., of the food preparation area found two (2) mixers (one large and one small) had dried food matter adhered to the underside of the rotary blades and on the splash guards. After gently touching the underside of the rotary blade, the dried food was easily dislodged. Observation, on 9/24/24, at 9:32 a.m., in the [LOCATION] food preparation area found the slicer soiled with food crumbs adhered to it. Dietary Staff A stated they could not recall when it had been used last. Also observed were two (2) can openers that were mounted on a food preparation table; one was missing a blade and the other one, which was on the opposite end of the table, had a visual buildup of a black, sticky matter on it that was easily removed. During an interview, on 9/24/24, at 9:36 a.m., Dietary Staff A was asked about the condition of food preparation equipment, and they stated the facility policy was to clean the equipment after each use. 3. During an observation and Interview, on 9/25/24, at 10:45 a.m., with Licensed Nurse C, concerning the refrigerator contents on the [LOCATION], the surveyor asked if they could show where residents stored their personal foods. Upon observation of the refrigerator's contents, two (2) undated and unlabeled sandwiches, both having luncheon meat and cheese in them, were observed, and neither were labeled or dated. When asked about the food items, Licensed Nurse C stated they were not certain who the sandwiches belonged to, or how long they had been in the refrigerator. There were also two (2) plastic bags with commercially prepared, deli type sandwiches in them that had a use by date. However, there was no label to identify any resident they belonged to, or how long they had been in the refrigerator. When asked about the items, Licensed Nurse C identified the name of the resident and said a family

	member brought them in for the resident to have as snacks. After opening another one (1) of the bags, an expiration date of 9/24/24 was found on one (1) of the sandwiches located in the bag. Licensed Nurse C continued to check the contents and found three sandwiches which were held beyond their use by date. On 9/25/24, at 10:55 a.m., during a check of the residents' refrigerator on the [LOCATION] with Administrative Nurse B, there were two loaves of bread found with a sell by date of 9/12/24. The bread was also not labeled to identify who the items belonged to, nor did it identify when they were placed in the refrigerator. Also observed in the refrigerator were two (2) grocery style bags which contained restaurant carry out foods; one was dated 9/24/24, but did not identify who the food belonged to; and the other bag observed did not have any label at all on it. In addition, another carton was found underneath those two (2) bags, and the date written across the top was 9/12/24, but it had no label to identify who the food belonged to, either. When asked who was responsible for monitoring the contents of the refrigerator, Administrative Nurse B pointed to a notice posted on the refrigerator which stated: "foods would be discarded every seven days, on Wednesdays." Furthermore, Administrative Nurse B acknowledged the carton found in the refrigerator, dated 9/12/24, was not labeled, and had been in the refrigerator for 13 days.
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	**Fire Safety and Operations** Based on observation and interview, the facility failed to provide the [LOCATIONS] with the required equipment. The deficient practice affected one (1) of seven (7) smoke compartments in [LOCATION], staff, and three (3) residents. The facility had a capacity for 304 beds with a census of 222 on the day of the survey. The findings include: Observation during a tour of the building, on 9/26/24, at 10:31 a.m., of the residents' [LOCATION] in the [LOCATION] between [LOCATION] and [LOCATION] revealed the area was not equipped with a metal container with self-closing cover devices into which ashtrays could be emptied, as required by section 19.7.4 (6) of NFPA 101, Life Safety Code. An interview, on 9/26/24, at 10:31 a.m., with Maintenance Staff A revealed the facility was aware of the requirement for [LOCATIONS] to be equipped with metal containers with self-closing cover devices into which ashtrays could be emptied.

	Additional interview with Maintenance Staff A revealed the other [LOCATIONS] were equipped with metal containers with self-closing cover devices, and they did not know where the container had gone. The census of 222 was verified by Administrative Staff A on 9/26/24, at 8:42 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 9/26/24, at 4:10 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7.4*** Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: **(1)** Smoking shall be prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. **(3)** Smoking by patients classified as not responsible shall be prohibited. **(4)** The requirement of 19.7.4(3) shall not apply where the patient is under direct supervision. **(5)** Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. **(6)** Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.
§ 51.210 (o) (1) Clinical records. (1) The facility management must maintain clinical records on each resident in accordance with accepted professional standards and practices that are— (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview and record review, the facility failed to have medical records readily accessible for one (1) resident reviewed. Specifically, Resident #37 did not have therapy assessments available for review to determine how a Broda chair was a fit for their best interest and quality of life. The findings include: A Clinical Records Access policy was requested from Administrative Staff A on 9/26/24, at 4:17 p.m. Administrative Staff A provided a policy titled, “Request for Personal Access, Use And/or Disclosure of Health Information,” dated as Reviewed/Revised May 2024. The Clinical Records Access policy was a disclosure provided to anyone requesting medical records and specified what information was being requested. The policy also contained the following information: “I hereby request permission from the [facility] Veteran’s Home [city] to

	allow personal access to health information maintained in my records as allowed by law." Record review of Resident #37's Face Sheet revealed they were admitted to the facility on [DATE], with the following diagnoses: Parkinson's Disease without Dyskinesia, Depression, Hypertension, and Chronic Kidney Disease Stage three (3). Record review of Resident #37's Minimum Data Set (MDS), dated [DATE], Brief Interview for Mental Status (BIMS), Section C Cognition revealed a score of six (6), indicating severe cognitive impairment. Record review of Resident #37's Minimum Data Set (MDS), dated [DATE], Section GG-Functional Abilities and Goals reflected Resident #37 did not have an impairment with their upper extremity (shoulder, elbow, wrist, hand), nor their lower extremity (hip, ankle, knee, foot). Record review of Resident #37's Nursing Admission/Readmit Screener, dated [DATE], revealed they were admitted from another facility and arrived in a wheelchair. Comments under Range of Motion (ROM)/ Motor Control read Resident #37 was visually seen to be able to move all extremities. Record review of Resident #37's electronic medical record did not provide physical or occupational therapy assessments to determine if a Broda chair was an ergonomic fit for them. In an interview with Consultant Staff C and Consultant Staff B, on 9/25/24, at 2:30 p.m., they both stated they did not have medical records or access to any assessments for Resident #37 because a new therapy contract took over in [DATE], and they were admitted in [DATE]. In an interview, on 9/26/24, at 1:35 p.m., Administrative Staff A confirmed a new therapy contract did take over the therapy department and stated that if they were to request existing records, there was no guarantee the surveyor would receive them. Administrative Staff A stated they did not have access to those medical records.