Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6014948	A. BUILDING: ______ B. WING ______	C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	**ONE VETERANS DRIVE MANTENO, IL 60950**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint Investigation 24754418/175395	S 000		
S9999	Final Observations Statement of Licensure Violation 340.1330a)1) 340.1505b) Section 340.1330 Serious Incidents and Accidents a) The facility shall notify the Department of any incident or accident that has, or is likely to have, a significant effect on the health, safety, or welfare of a resident or residents. Incidents and accidents requiring the services of a physician, hospital, police or fire department, coroner, or other service provider on an emergency basis shall be reported to the Department. 1) Notification shall be made by a phone call to the Regional Office within 24 hours of each serious incident or accident. If the facility is unable to contact the Regional Office, notification shall be made by a phone call to the Department's toll-free complaint registry number. Section 340.1505 Medical, Nursing and Restorative Services b) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing care needs of the resident.	S9999		

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These regulations are NOT MET as evidenced by:

Based on observation, interview, and record review, the facility failed to provide adequate supervision to a resident with known exit-seeking behaviors to prevent him from leaving the facility unsupervised. This failure resulted in R1 eloping from the facility and being discovered by passing motorists. R1 sustained fractured ribs, bruising to his orbital area, and multiple facial, hand, leg, and hip abrasions. The facility also failed to report this incident as elopement but as a change in condition to the state agency.

This applies to 1 of 3 residents (R1) reviewed for elopement risk and supervision in the sample of 3.

Findings include:

R1's Brief Interview of Mental Status dated 05/09/2024 documents R1 as oriented to person only. R1's Admission Record documents R1 admitted on 05/03/2024 with diagnoses that include dementia with behavioral disturbance.

The resident was discovered by passing motorists in the ditch on Illinois 4000 Road North, close to Illinois 9000 road. This two lane route does not have a shoulder, sidewalk or crosswalks to safely traverse.

On 07/11/2024 at 11:26 AM, V15 (Motorist) stated "Me and a friend were driving on 4000 road on Saturday (07/06/2024) It was around 01:15 (PM). She spilled her drink all over her phone then took the case off and held her phone out the window to dry it off....the phone went flying out of her hand into the ditch. I turned the car around, drove back

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and we both got out and searched for it. We didn't see the phone so we got back in the car and headed north on 4000 road. As we got going I thought I saw a man lying in the ditch off the side of 4000 and 9000 roads. I stopped the car and yes, here was this guy lying on his back in the weeds and really looking bad. He was wearing a sweater, long pants and all cut up bleeding. He was soaked from head to foot with sweat. I asked him what was going on and if he needed a ride. He had no idea what was going on...he didn't know where he lived or how he got there. We asked to give him a ride and he accepted. I saw the US Army badge on his hat and his lunch box had "Unit 4" written on it. I thought perhaps he lives at the (facility) down the street. We drove him there and got him inside. When I asked the unit 4 nurse if they knew the man, I was told 'He's not ours.' I asked if they could call the other units to check and see if he even belongs at this facility. The unit 4 nurse said he called the shift coordinator (V5 Registered Professional Nurse {RN}) but no one ever showed up. About 30 minutes later (V6 RN) arrived and announced that (R1) was hers and that dietary staff must have let him out."

A computerized web mapping platform documents the distance between the facility and the roadside ditch where R1 was found was a distance of 1.0 mile. The temperature as recorded by TimeandDate.com on July 6, 2024 at 12:00 PM in Manteno recorded 81 degrees Fahrenheit.

On 07/10/2024 at 1:45 PM, R1 was observed in the commons day room. There was bruising to his lower right eyelid down to his cheek. R1's nose had abrasions and was reddened and swollen. His right arm had bruising to his wrist

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and lower arm. During the interview, R1 was unable to describe the events of 7/06/2024. R1's Elopement Risk Assessment dated 5/03/2024 documents R1's risk for elopement. His assessment score was 8.0, with a score of 6.0 or greater identifies the resident is at risk for elopement.

R1's Progress note dated 06/10/2024 at 9:59 AM documents "Member is refusing his shower, noted previous day and today that he is easily agitated reporting wanting to leave, difficulty calming and redirecting." R1's 2:41 PM progress note showed "Exit seeking all day; reports he has to go to work, has to get out of here; redirection and he continues to wander looking for an exit; only minimally agitated." R1's 6/15/2024 Progress at 11:22 AM documents "Walking around the unit with clothes, stating "I'm leaving." R1's 6/21/2024 Progress note at 7:33 PM documents "Keeps saying "I'm out of here in the morning, these guys here are nuts"; reassurance given, assured him he has a place to sleep; redirects easily; takes dinner then is ready to go to bed." R1's 6/22/2024 Progress note at 9:30 AM documents "...staff keeps bringing him back to unit, member is agitated and verbally antagonizing their members; VNAC here reports member has been threatening members on this unit saying "He is such a slob, I should just shoot them all"; tells myself that he is going to pack and leave with his nephew; offered alternative things to calm him, refuses all; encourage to sit on couch in living area away from other members and does so, snacks and drink given." R1's 6/23/2024 Progress Note at 4:57 PM documents "Insisting on leaving and going home to herd the cattle; difficulty redirecting until drinks and snack given, had him sit at table with others." R1's 7/1/2024 Progress Note at 12:30 PM documents

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"Member verbalizes the desire to leave the facility and sits on [unit name] watching the exit doors."

The Progress Note dated 07/6/2024 from 3:38 PM documents "Received a call from shift coordinator at 1340 (1:40 PM) telling me that this member is on [unit name] dining room, had been picked up by passer byers (sic) from a ditch and brought back to the facility; I walked down to that unit, assessed his face and arms, talking as per his normal but unable to say what happened or where he was going; called Dr. from that unit, orders to be sent to (local hospital) ER for evaluation; ambulance arrives within minutes of call, arrived by approx 1415 (2:15 PM); once back on unit [name] (Power of Attorney) called at 1440 (2:40 PM)."

The Progress Note dated 07/06/2024 at 03:49 PM documents "Fall Note Date/time of fall: 07/06/2024 - 2:00 PM. Narrative of fall: observed at 1350 (1:50 PM) in dining area of [unit name], observed member with discoloration to lower right eyelid down to cheek, nose with abrasion, reddened and swollen, right arm with discolored area to wrist and lower arm; unable to assess rest of body due to being in public area; ambulance arrival and then member [complained of] left neck pain, paramedics informed by myself that member does not [complain of] pain so if he does (even though he is confused) that it will need to be addressed; ...no equipment to take VS; information taken from persons who brought him back to facility; as described member is unable to say what happened or how he left the unit."

R1's 7/6/2024 Progress Note at 18:25 (6:25 PM) documents "Returns from hospital via stretcher accompanied by paramedics, paperwork

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received; CT brain, cervical spine, facial bones negative; labs WNL [within normal limits]; facial bruising and nose redness with swelling; dinner served; in good spirits; neuro status WNL for this member;VS WNL except B/P slightly elevated at this time 140/89."

R1's 7/7/2024 Wound Eval showed:
"New Wound~ Yes, Onset 07/06/2024. Rt hand, back Deep Tissue Injury. Wrist up to mid forearm grey discoloration 15cm (centimeters) x 5cm.
2. New Wound~ Yes, Onset 07/06/2024. Face and Nose. Deep Tissue Injury. 7 cm x 6 cm.
#3. New Wound~ Yes, Onset 07/06/2024. Lt elbow. Deep Tissue injury. 7 cm x 6 cm."

R1's 7/9/2024 Progress Note at 11:34 AM documents "Informed by social worker, member complained to his son of pain to his right rib cage on 7/8/24. Body assessment completed, no redness or bruising noted to chest, [complained of] discomfort to right rib cage with gentle pressure. Respirations easy non-labored, saturation 97% on room air. Informed of plan to have MD to eval on rounds. Vitals documented."

R1's 7/10/2024 Progress Note at 9:39 AM documents "X-ray report received. [Fracture] x2 to right rib. Dr. aware. Spoke to social service." The Radiology Report dated 07/09/2024 document "Clinical Information: RIGHT RIB CAGE PAIN Right RIBS, Unilat, 2 Views. Findings: Examination Multiple views of the ribs right; Findings- Right lateral fourth and fifth rib fractures."

On 07/10/2024 at 1:30 PM, V9 (Veterans Nursing Assistant Certified [VNAC]) stated "(R1) was on my hall (07/06/2024). He had eaten lunch at noon and was watching the door. Around 12:30

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(PM) I was letting a family member out the locked door/unit and (R1) tried to walk out with them. Of course I stopped him from leaving. I can't say for sure what time I last saw him on the unit."

On 07/10/2024 at 10:30 AM, V1 (Administrator) stated "The unit is locked with a keypad. We do not give the code to anyone but staff. No visitors or family have the code. The only way on or off the unit is if staff let you in and out."

The Facility Policy Elopement/Wandering Risk Evaluation dated (reviewed) 07/2023 documents "IVHM (Illinois Veterans Home Manteno) shall provide adequate and properly supervised nursing care to each resident to meet the total nursing care needs of the resident. All residents will be assessed for behaviors or conditions that put them at risk for elopement, including mental and emotional changes. All residents so identified will have these issues addressed in the health care record and plan of care. Elopement risk will be defined as any resident who scores 6 or greater on the Wandering Elopement Risk Evaluation UDA and is at risk for elopement and/or made actual attempts of elopement."

The facility's policy, Abuse Prevention Program dated (revised/reviewed) 10/2019 documents "It is the policy of the Illinois Veterans Home at Manteno that all members will remain free from....neglect... This facility prohibits... neglect... of its members and is committed to being proactive in providing for the well-being of all residents by the recognition and prevention of abuse and training and prevention measures." Under Definitions is documented "Neglect: Failure to provide goods and services necessary to avoid physical harm, mental anguish.... or that result in the deterioration of a resident's physical

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or mental condition. The refusal or failure to provide a resident with such life necessities as... personal safety, and other essentials is considered neglect. Examples of neglect may include, but are not limited to: the lack off timely assessment/failure to assess individuals after injury, lack of supervision for an individual with known special needs.... and lack of supervision of cognitively impaired residents with known elopement risk."
" This policy documents under VIII. External Reporting of Abuse. "1. Initial Reporting of Allegations. If mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed as soon as possible within 24 hours... During off-hours fax the report to the regional office." The policy further showed "2. Five Day Final Abuse Investigation Report. Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health."

The facility's Initial Incident entry for R1 on the Illinois Department of Public Health's (IDPH) Regional Office 2024 Incident Log dated 7/10/2024 listed this incident concern under the Incident Category of "Change in Condition." This entry was reported as a concern from 7/10/2024 (four days after R1's Elopement) and it showed "[R1, date of birth, and age] complained of right rib pain during a follow-up examination from [physician] for a fall on 7/6/24. MD ordered mobile x-ray to be completed. Right rib unilateral 2 view completed, impression: fourth and fifth rib fracture. [R1 diagnosis of unspecified dementia unspecified severity with other behavioral disturbance and other diagnoses and

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medications.] Member remains at facility and will be monitored. Pain will be managed per MD and nursing staff." The Initial notification of R1's "Change in Condition" on 7/10/24 does not contain any reference to R1's Elopement on 7/6/2024, or that R1's 7/6/2024 fall occurred in a ditch outside the facility. Additionally, there is no separate Incident entry on the Log that showed R1 eloped from the facility on 7/6/2024 and was found injured in a ditch.

On 07/11/2024 11:59 AM, V1 Administrator stated "The final (report) will be completed tomorrow (07/11/2024) and the change of condition should be done." As of 7/18/2024, there is no initial or final notification of R1's 7/6/2024 elopement incident on the IDPH Incident Log.