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 02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S 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 #1770696/IL#91554	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS 340.1505b)5) 340.1505g) 340.1300a) Section 340.1505 Medical, Nursing and Restorative Services b) The facility shall 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 resident care plan. Adequate and properly supervised nursing care shall be provided to each resident to meet the total nursing care needs of the resident. 5). All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as necessary in an effort to help them retain or maintain their highest practicable level of functioning. g) All necessary precautions shall be taken to assure that the resident's environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 340.1300 Facility Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the	S9999	**Attachment A** **Statement of Licensure Violations**	

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 02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S 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
S9999	Continued From page 1	S9999		

administrator. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the facility's advising physician or the medical advisory committee, as evidenced by a dated signature.

These regulations were not met by:

Based on interview and record review the facility failed to provide the appropriate amount of staff to assist in mechanical transfers of residents. The facility also failed to follow the policy for mechanical lifting devices. As a result the resident fell from the mechanical lift and sustained a subdural hematoma.

This applies to 1(R1) of 3 residents reviewed for falls/mechanical lift transfers .

The Findings Include:

On February 7, 2017 at 9:15AM, R1 was sitting in an adult recliner chair. R1 did not recall the fall that occurred on February 1,2017. R1's Face Sheet documents the following pertinent diagnosis' Alzheimer Disease, Dementia with behavioral disturbances and Legal blindness. R1's last quarterly Minimum Date Set dated November 14, 2016 and Care Plan for Self Care Deficit/ Fall Care plan dated November 23, 2015 states R1 requires extensive assist with 2 staff for transferring.

Nursing Progress Notes and Incident Report dated February 1, 2017 document R1 fell from a mechanical lifting device, was transported to the hospital and diagnosed with a subdural hematoma. Hospital Record dated February 1, 2017 states, R1 was treated for a subdural

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 02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S 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
S9999	Continued From page 2	S9999		

hematoma on February 1, 2017 and discharged back to the nursing home on February 2, 2017 in stable condition.

On February 7, 2017 at 8:55AM, E3(Nurse) said on February 1, 2017 she was not paying attention when E4(VNAC, Veteran Nursing Assistant Certified) transferred R1 using a mechanical lifting device. E3 said R1 fell out of the lift onto his head and was transported to the hospital.

On February 7, 2017 at 9:25AM, E4(VNAC) said on February 1, 2017 she(alone) was transferring R1 from the bed to the chair using a mechanical lifting device. E4 said the strap became undone and R1 fell onto the floor. E4(VNAC) said E3(Nurse) was outside of the room during the transfer of R1. E4 said she stayed with R1 who did not lose consciousness while E4 went to get supplies to get the vital signs. E4 said she was disciplined for transferring R1 alone.

On February 7, 2017 at 10:04AM, E2(Acting Director of Nursing) and E5(Nursing Supervisor) said, they investigated the incident and provided training for all staff to utilize 2 staff persons when using mechanical lifting devices.

R1's care plan initiated on December 8, 2014 and reviewed on November 22, 2016 lists under interventions/tasks,
"Transfer: the resident requires extensive assist times (x) 2 staff for transfers."

The Facilities Policies for Mechanical Lifting Devices last revised on April 2009 state, " When operating the lift you must have 2 staff members assisting at all times."

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 02/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT MANTENO	ONE VETERAN'S 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
S9999	Continued From page 3 (B)	S9999		