

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015473	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2026
NAME OF PROVIDER OR SUPPLIER ILLINOIS VETERANS HOME AT QUINCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1707 NORTH 12TH STREET QUINCY, IL 62301		
(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 Investigation of : Complaint 2621745/200127-300.1978 f)g) Complaint 25212095/19895- no findings Complaint 2622701/200559- unable to be investigated, resident does not reside in this facility	S 000		
S9999	Final Observations Statement of Licensure Violations: 340.1378f) 340.1378g) Section 340.1378 Resident Attendants f) The facility shall develop and implement policies and procedures concerning the duties of resident attendants in accordance with this Section, and shall document such duties in a written job description. g) As part of the comprehensive assessment, each resident shall be evaluated to determine whether the resident may or may not be fed, hydrated or provided personal hygiene by a resident attendant. Such evaluation shall include, but not be limited to, the resident's level of care; the resident's functional status in regard to feeding, hydration, and personal hygiene; and the resident's ability to cooperate and communicate with staff. These requirements were not met as evidenced by:	S9999		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 Based on interview and record review the facility failed to transport one resident (R2) safely to the hospital after a change in condition of three residents reviewed for transportation to the hospital. Findings Include: The Facility's "Resident Transport Guidelines-Driver/Nursing Staff" policy dated 01/2023 documents "(This Facility) when serving on trips, have a responsibility to provide for the well being of residents." The policy lists driver's responsibilities as following the rules of the road, ensuring straps are secured for seat belts either on the resident's person or on the resident's person and their wheelchair. R2's Medical Record documents he was admitted on 7/15/25 with diagnosis to include but not limited to Low Back Pain, Type II Diabetes Mellitus and Anxiety. R2's Nurse's Notes on 2/12/26 document R2 had a headache of 8 out of 10 on a pain scale of 0-10 not relieved with Percocet (Narcotic Pain medication). R2's blood pressure after administration of his Percocet and Midodrine (to increase his blood pressure) caused his blood pressure to drop to 80/41. R2's Nurse's Notes document R2 "left with security"(Facility non medical transportation). V18 (Registered Nurse) was the nurse who documented R2 being sent to the emergency room via security. V18 (RN) was not available for interview throughout the survey. On 3/25/26 at 2:00 PM V7 (Emergency Medical Technician) stated "We have picked (R2) up (for	S9999		

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S9999	Continued From page 2 transport to the Emergency Room) before. He gets very sick very quickly. He needs emergency transportation every time. (R2) is unstable. He needs someone who can start IV (Intravenous therapy) do an EKG (Electrocardiogram) and give him medicines for his blood pressure. He does not just need a ride to the hospital." On 3/25/26 at 10:00 AM V2 (Registered Nurse/Director of Nursing) stated that the facility does have employees known as their "security team" who drive residents to the hospital for non emergent emergency room visits. V2 stated that the facility has on call providers (Nurse Practitioners) that make the decision who needs to go via ambulance and who is safe to transfer via facility's security. V2 stated "with that low of a blood pressure and the unrelieved headache, a provider would have had to give the order to send (R2) via security instead of an ambulance." On 3/26/26 at 9:00 AM V14 (Nurse Practitioner) stated she was not the Provider who dealt with R2 on 2/12/26. V14 stated that she had been contacted about sending R2 to the hospital in the past for the same set of symptoms and she instructed nurses to send via ambulance. "I said send him 911." V14 said "(R2) was a very sick guy." On 3/26/26 at 10:00 AM V15 (Nurse Practitioner) stated he was the Provider the nurses called on 2/12/26. "I told the nurse to send (R2) 911. (R2) needed an ambulance with a low blood pressure and headache unrelieved with narcotics." V15 provided his handwritten "call journal" that documents a hand written note dated 2/12/26 "(R2) low b/p (blood pressure) HA (headache) not better after Perc (Percocet). To ER (Emergency Room) 911." The "security team" that transfers a	S9999		

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S9999	Continued From page 3 resident have no medical training, cannot start an IV, can not use AED (Automated External Defibrillator) or perform CPR (Cardiopulmonary Resuscitation) because the driver is alone with the resident. "The risks of sending (R2) with just a driver was great. He could have had an MI (Myocardial Infarction), a brain aneuerysm or started seizing which he has done in the past. He could have had poor outcomes up to and including death from being transferred non emergently, absolutley." On 3/26/26 V2 (RN/DON) confirmed there was no written order for transport to the emergency room for evaulation and treatment in non emergency fashion. V2 also confirmed that there was no documentation of notification of the provider (V15/Nurse Practitioner) or what his orders were for resident. "I don't know why (R2) was sent via security instead of ambulance." (B)	S9999		