

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 03/27/2021 |
|--|--|---|---|

| | |
|---|---|
| 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 | S 000 | | |
| | <p>Facility Reported Incident of 3/15/21/IL132056.</p> <p>S9999 Final Observations</p> <p>Statement of Licensure Violation:</p> <p>Section 340.1505 Medical, Nursing and Restorative Services</p> <p>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.</p> <p>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.</p> <p>This requirement is not met as evidenced by:</p> <p>Based on interview, observations and record reviews, the facility failed to keep an environment safe and the walkway free of clutter to prevent a fall for one (R1) of three residents reviewed for falls in the sample of three.</p> <p>Findings include:</p> <p>A facility Fall Evaluation policy dated 6/18 documents: "Fall Evaluation, policy: To ensure accurate evaluation of all resident falls. Definition: A fall is defined as an unintentional change in position coming to rest on the ground, floor or</p> | S9999 | <p style="text-align: center;">Attachment A Statement of Licensure Violations</p> | |

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 03/27/2021 |
|--|--|---|---|

| | |
|---|---|
| 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 |
|--------------------|---|---------------|---|--------------------|
| S9999 | <p>Continued From page 1</p> <p>onto the next lower surface (e.g. onto a bed, chair, or bedside mat). The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground. Falls include any fall, no matter whether it occurred at home, while out in the community, in an acute hospital or a nursing home."</p> <p>A facility Fall Management Program Policy dated 11/17 documents: "5. All staff of the interdisciplinary team will confirm: a. Hallways and resident areas are well lit, b. Hallways and resident areas are uncluttered and free of spills; c. Locked doors are kept locked when unattended; d. Handrails are secure and unobstructed; e. Tables and chairs are sturdy. f. Resident rooms are set up in a way that minimizes the risk of falling; g. Unsafe situations are dealt with immediately either by dealing with the situation or notifying the appropriate staff and ensure that they arrive and correct the situation; and h. Ensuring that all equipment on the units are working properly and receiving maintenance as applicable.</p> <p>A current face sheet documents that R1 was admitted to the facility on 5/22/2014. R1's most recent brief interview for mental status documents a 14 out of 15 (Cognitively intact) and functional status documents that R1 walks in room and in corridor independently.</p> <p>R1's current care plan documents: "The resident is at High risk for falls r/t (Related to) psychotropic drug use, history of falls, forgets limitations, impaired gait and balance, walks without straight cane at times, hx (history of) refusal to wear non-skid footwear while ambulating, multiple dx (diagnosis) that could contribute to falls; The resident needs a safe environment with: even</p> | S9999 | | |

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 03/27/2021 |
|--|--|--|---|

| | |
|---|---|
| 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 |
|--------------------|---|---------------|---|--------------------|
| S9999 | <p>Continued From page 2</p> <p>floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed at knee height, and personal items within reach. Ensure pathway is clear of cords and that cord to the filter is secured out of walkway."</p> <p>A facility reported incident dated 3/15/2021 documents: "(R1) found on the floor of (R1)'s room. (R1) stated (R1) tripped on the cord to the HEPA (high-efficiency particulate air) filter in room and fell hitting head on the floor. Upon assessment (R1) had full range of motion. (R1) stated he did not lose consciousness, right eye was sluggish to light with neuro (neurological) check, and laceration with bleeding was noted to the center of (R1)'s forehead. (R1) transferred via ambulance to hospital and received seven sutures to the laceration to (R1)'s forehead and a CT (Computed Tomography) scan of the brain that was negative. (R1) was admitted to hospital for overnight observation for head."</p> <p>A Fall Incident Report investigation dated 3/15/2021 documents: "(R) sustained a 4 centimeter laceration to the center of his forehead due to a cord to a HEPA filter being in the front of the machine instead of in the back of machine and that cord should be pushed back under the upright filter to unclutter the walkway."</p> <p>A Follow-up report dated 3/23/2021 to incident of 3/15/2021 documents: "Conclusion: After thorough investigation and incident being witnessed, it was determined through the witness statement that the fall most probably occurred due to the resident (R1) tripping over a cord in his room and losing his balance."</p> <p>On 3/26/2021 at 11:45 a.m., R1 was sitting in his recliner. R1 stated that he was ambulating back</p> | S9999 | | |

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 03/27/2021 |
| 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 | |
| S9999 | <p>Continued From page 3</p> <p>from the bathroom and tripped over a long black cord that was out in the middle of the room on the floor. R1 pointed to his forehead and said, "See my scar." R1 then stated that he had to have several stitches. R1 also pointed to the HEPA air filtration system located next to the wall in his room.</p> <p>On 3/26/2021 at 11:45 a.m., an air filtration system was in R1's room along side the wall with the cord coiled up behind the unit.</p> <p>On 3/26/2021 at 1:00 p.m., V3 Public Service Administrator, Nursing Supervisor stated that (R1) had a fall from tripping over a cord that was in his path and that R1 received medical treatment requiring sutures to his forehead as well as an overnight stay at a local hospital. V3 further stated that the cord should have been coiled up and placed to the back of the machine and not in the path of where the resident walks.</p> <p>On 3/26/2021 at 12:00 p.m., V2, Director of Nursing, stated that the cord should have been tucked behind the air filtration unit and that (R1) tripped and fell due to the cord being in the walkway.</p> <p>(B)</p> | S9999 | | | |