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 04/08/2025

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

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S 000	Initial Comments Investigation of Facility Reported Incident of 3/27/2025/IL189495 - Section 340.1440 Abuse and Neglect 340.1440 a) 340.1440 b) 340.1440 e)	S 000		
S9999	Final Observations Statement of violations: 340.1440 a) 340.1440 b) 340.1440 e) Section 340.1440 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the	S9999		

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employee. (Section 3-611 of the Act).

The requirement is not met as evidenced by:

Based on interviews and record review, the facility failed to prevent verbal abuse to a resident by an employee and failed to provide coffee to a resident with history of requests for the same. Facility also failed to immediately report the incident to administration and failed to immediately bar the perpetrator from any further contact with residents.

This applies to 1 of 3 residents (R1) reviewed for abuse in the sample of 5.

The findings include:

R1's EMR (electronic medical records) showed that R1 is a 96 year old male with diagnoses including type 2 diabetes mellitus without complications, hypertension, benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, unspecified systolic congestive heart failure, mild cognitive impairment of uncertain or unknown etiology, other frontotemporal neurocognitive disorder.

R1's quarterly MDS (minimum data set) dated March 3, 2025 showed that R1 was cognitively intact and required supervision with touching assistance for eating.

R1's Physician Order Summary showed diet order of Lactose Controlled diet, General texture, Regular consistency, avoid fatty and high fiber diet, no milk products. Member may have decaf coffee....(revised date April 1, 2025).

Physician progress note dated April 2, 2025

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included that R1 "receives a regular diet but with decreased lactose content. This diet seems to serve him well without causing any problems. He did have chronic diarrhea but low-dose Sevelamer was adequate to control it." Facility provided information that Sevelamer is a medication that can be used to control diarrhea.

Nutrition care plan revised March 2, 2025 included as follows: R1 has potential for nutritional problem due to dementia, coronary artery disease cardiovascular diseases, hypertension, type 2 diabetes mellitus, cognitive impairment and being in a new environment. R1 is alert, able to feed self after a tray set-up with supervision at times while eating to ensure proper nutritional intake.... Interventions included to provide and serve diet as ordered. General diet with thin liquids - banana at breakfast - 120 ml (milliliters) high calorie nutrition supplement two times daily. No milk products - no oatmeal - avoid fatty and high fiber foods (revised July 6, 2023).

On April 7, 2025 at 12:01 PM, R1 was seated in a specialized wheel chair in his room. When asked if he gets coffee R1 responded "I get a little bit of coffee, half cup every three days. I don't get it every day. Why did they take it away. I miss my coffee. It's a good question why I don't get it. I have diarrhea and am shitting all the time. They tell me I shouldn't have coffee. But there is nothing else to drink. I am 96 years old and should be allowed to have it."

On April 7, 2025 at 10:01 AM, V3 (Social Service Director) stated that the incident happened on March 26, 2025 around 3:00 PM. V3 stated that she was delivering snacks out to the residents and she encountered R1 in the snack area. V3 stated "He was sitting in his chair looking at the

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coffee pot on the counter top. I asked him if he needed anything and he asked for a cup of coffee. Knowing him previously, I knew he could drink thin liquids so I made him a cup of coffee. When I gave him the coffee he started crying and told me that the staff will not let him have coffee. Right about that time [V5] (Registered Nurse) came in and stated that [R1] cannot have coffee for it can cause him to have diarrhea. By that time, [R1] had asked for a second cup of coffee. I told [R1] that the staff was recommending that he does not have coffee as it causes diarrhea and knowing this, he said yes that he wanted to have the second cup of coffee. So I gave him a second cup of coffee. As I was leaving the snack area, I was confronted by [V4] VNAC (Veterans Nursing Assistant Certified) who stated that [R1] is not allowed to have coffee, as quote 'he would shit all the way up his back.' She said this in front of [R1]. There was another VNAC there and I do not know her name. There was also another resident passing by in his wheelchair and I do not know his name. I went and talked to the nurse [V5] and said to him what [V4] she had said was not appropriate especially in front of [R1]."

V3 continued stating that V5 was defending V4 and felt that R1 should not have coffee. V3 stated that it was not documented anywhere that R1 cannot have coffee and there was no order for the same and that R1 did not have an allergy for coffee. V3 stated that she explained to V5 that she had seen R1 drinking coffee at other social gatherings and that it was his right to have coffee. V3 stated that since V5 did not agree with anything, she chose to walk away and report the incident to V1 (Administrator) and V2 DON (Director of Nursing) the following morning (March 27, 2025). V3 stated that she did not report the incident immediately because she was

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so stunned by the incident. V3 stated that she knew it wasn't right but had to think about it to conclude how it would impact the resident.

On April 7, 2025 at 9:45 AM, 1:00 PM and 2:29 PM, V1 stated that she is the abuse coordinator and was notified on March 27, 2025 morning about the incident by V3 and that she reported it to IDPH (Illinois Department of Public Health) the same day. V1 stated that the interviews were done by V2 (DON) and V9 (Assistant Director of Nursing). V1 stated that the interviews were corroborated related to interviews done with V3 and V5, and substantiated. V1 stated that V4 admitted that she said it (above phrase). V1 added that V4 works the 3-11 PM shift and only came in for the interview on March 27, 2025 (evening) and had no contact with the residents thereafter and was placed on administrative leave.

On April 8/2025 at 1:37 PM, V2 confirmed that V4 usually works 3PM-11PM shift and that on March 26, 2025 V4 worked overtime and worked until March 27, 2025 7:00 AM.

V4's time card report dated March 26, 2025 included that V4 worked 16.13 hours and had clocked in at 2:52 PM on March 26, 2025 and worked until 7:00 AM (March 27, 2025).

Facility follow up report to IDPH dated April 1, 2025 for above incident included the following conclusion: "Interviews conducted with employees present during this interaction and this event was corroborated. [V4] acknowledges that she made that statement and is aware that this is inappropriate..."

Facility policy and procedure titled "Abuse

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Prevention program" (Revised July 2024) included as follows:

Abuse: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is a willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual including caretaker, of goods or services that are necessary to attain and/or maintain physical, mental, and psychological well being.....

Verbal Abuse: This is the use of oral, written or gestured language that willfully includes disparaging terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend or disability. It includes staff yelling, swearing, threats of harm, gesturing or using derogatory obscenities and /or threatening language.

V. Internal Reporting Requirements and Identification of Allegation
Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, or misappropriation of property they observe, hear about or suspect to the administrator or the person in charge of the facility acting on behalf of the administrator, or an immediate supervisor who must then immediately report it to the administrator.

V1. Protection of Residents
....Employees of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee.

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S9999	Continued From page 6 Employees accused of possible abuse, neglect or misappropriation of property shall not complete the shift as a direct care provider to the residents. (B)	S9999		