

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER ILLINOIS VETERANS HOME AT MANTENO		STREET ADDRESS, CITY, STATE, ZIP CODE 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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of licensure violations: 1 of 6 340.1305b) Section 340.1305 Request for Resident Criminal History Record Information b) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. The requirement was not met as evidenced by: Based on interview and record review, the facility failed to perform complete background checks for residents upon admission. This failure applies to 10 of 10 residents (R6, R10, R11, R12, R13, R14, R15, R16, R17, and R18) reviewed for criminal background checks in a sample of 18 residents. The findings include: 1. R6's EMR (Electronic Medical Record) showed R6 was admitted to the facility on July 30, 2025 , 2. R10's EMR showed R10 was admitted to the facility on September 4, 2025	S9999		

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

TITLE

(X6) DATE

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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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S9999	Continued From page 1 3. R11's EMR showed R11 was admitted to the facility on August 6, 2025. 4. R12's EMR showed R12 was admitted to the facility on August 27, 2025. 5. R13's EMR showed R13 was admitted to the facility on August 27, 2025 6. R14's EMR showed R14 was admitted to the facility on September 29, 2025 7. R15's EMR showed R15 was admitted to the facility on September 22, 2025 9. R16's EMR showed R16 was admitted to the facility on September 18, 2025 9. R17's EMR showed R17 was admitted to the facility on August 22, 2025 10. R18's EMR showed R18 was admitted to the facility on September 24, 2025 R6, R10, R11, R11, R12, R13, R14, R15, R16, R17, and R18's background check records did not include an Illinois Department of Corrections Sex Registrant background report. On October 8, 2025, V4 stated that background checks for residents are run within 24 hours of admit to facility. V4 stated that she is the facility Reimbursement officer. V4 stated that the following should be run: IL State Police sex Registry, Illinois Department of Corrections (IDOC) Registry, however was not aware that she needed to run the Illinois Department of Corrections sex Registry. V4 stated that on the IDOC registry they are to look up the individual in custody search for inmates and the Chirp is done	S9999		

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S9999	Continued From page 2 after admission. The facilities policy entitled "Illinois Department of Veterans Affairs Policy Admission of Residents" Revised on January 5, 2017 states in part: " The Facility shall check for individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us/sor and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us/subsections/sosearch/default.asp to determine if the individual is listed as a sex registered offender." (C) 2 of 6 340.1335c)2) Section 340.1335 Infection Control c) Each facility shall adhere to the following guidelines and toolkits of the Center for Infectious Diseases, Centers for Disease Control and Prevention, U.S. Public Health Service, Department of Health and Human Services, and Agency for Healthcare Research and Quality (see Section 340.1010): 2) Guideline for Hand Hygiene in Health-Care Settings. This requirement is not met as evidence by: Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene and gloving during provisions of peri-care and wound care. This failure applies to 2 of 2 residents (R7, R9)	S9999		

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S9999	Continued From page 3 reviewed for infection control in a sample of 9 residents. The findings include: 1. On October 8, 2025, at 10:00 AM, R7 was resting in bed with an indwelling urinary catheter. V10 (Nurse) applied Zinc Sulfate ointment to R7 from back to front of his perineum while wearing the same gloves. After V10 applied the Zinc Sulfate, V8 and V9 (Both Certified Nursing assistants/CNA) assisted R7 to change his incontinence brief, transfer R7 from bed to wheelchair, and removed soiled linens. V8, V9, and V10, changed gloves, however, they did not perform hand hygiene before providing care, in between tasks, and before they left the bedroom. On October 8, 2025, at 1:44 PM, V17 (Infectious Preventionist) stated that when the staff provides care, they should perform hand hygiene prior to providing care, in between tasks and before leaving the bedroom. They also require changing gloves from dirty to clean tasks to prevent cross contamination and prevent spread of potential infection. 2. R9's admission record showed R9 was admitted to the facility with diagnoses that included morbid severe obesity due to excess calories, heart failure, chronic obstructive pulmonary disease and osteomyelitis of vertebra, sacral and sacrococcygeal region. On October 8, 2025 at 11:02 AM, during observation of wound care for R9, V12 (Wound Care Nurse) entered R9's room without performing hand hygiene. R9 did not perform hand hygiene while in R9's room either. V12 and V13 (Certified Nursing Assistant/CNA) removed a	S9999		

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S9999	Continued From page 4 brown stained sheet from R9's lower body. V13 then held R9's to the side for V12 to treat R9's stage 4 coccyx wound. After V12 cleaned R9's wound with saline and gauze dressing she then removed her gloves. V12 then put on another pair of gloves but did not perform hand hygiene. There was a hand sanitizer dispenser full of sanitizer and in working order behind V12 on the wall. V12 then started applying R9's wound treatment. V12 finished R9's wound care treatment and left the room with the same gloves on. V12 was carrying some gauze and saline in one hand and garbage in the other hand. V12 did not remove her gloves or her gown, nor did she perform hand hygiene before leaving R9's room. V13 also did not perform hand hygiene after removing her gloves and gown and before leaving R9's room. On October 8, 2025 at 2:00 PM V2 (Director of Nursing) stated she expects her staff to perform hand hygiene before entering a room with a resident on EBP. Staff should be wearing a gown and gloves. V2 stated that when moving from dirty to clean, staff should remove gloves and wash their hands. V2 stated staff should perform hand hygiene when moving from clean to dirty in order to prevent the spread of bacteria and protect resident and staff from the spread bacteria. The facility's Hand Hygiene policy revised March 19, 2024 showed the following: Staff members should perform hand hygiene for the clinical indications listed below: Immediately before touching a patient; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or the patient's immediate environment; after contact with blood, body fluids, or contaminated surfaces; and	S9999		

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S9999	Continued From page 5 immediately after glove removal. (B) 3 of 6 340.1410a)1) Section 340.1410 General a) No resident shall be deprived of any rights, benefits, or privileges guaranteed by State or federal law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of their status as a resident of a facility. 1) Residents shall have the right to be treated with courtesy and respect by employees or persons providing medical services or care and shall have their human and civil rights maintained in all aspects of medical care as defined in the State Operations Manual for Long-Term Care Facilities. The REQUIREMENT was not met as evidenced by: Based on observation, interview, record review the facility failed to ensure privacy for a resident while providing wound care. This applies to 1 of 1 resident (R9) reviewed for privacy in the sample of 18. Findings include: R9's admission record showed R9 was admitted to the facility with diagnoses that included morbid severe obesity due to excess calories, heart failure, chronic obstructive pulmonary disease and osteomyelitis of vertebra, sacral and	S9999		

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S9999	Continued From page 6 sacrococcygeal region. On October 8, 2025 at 11:02 AM, during wound care treatment for R9 with V12 (Wound Care Nurse) and V13 (Certified Nursing Assistant/CNA), V12 closed the door to R9's room but did not close the window shades of the window directly in front of R9. The shades were drawn all the way up to the top of the window. R9's bed is about a 1.5 to 2 feet away from a large window that looks out onto a walkway, a ramp to exit the building, and 2 other large windows facing R9's windows. V13 pulled R9 towards her and towards the window, and V12 removed the brown stained sheet from R9's buttocks and pubic area. R9 was then completely naked, and his pubic area was exposed and facing the open window. V13 was standing in front of R9 with her frame covering R9's large abdominal area. After V12 finished cleaning and dressing R9's wound, V13 R9's bare pubic area exposed to the open window and left the room. On October 8, 2025 at 4:10 PM, R9 stated that when staff is performing care they never close the window shades. On October 8, 2025 at 2:00 PM, V2 (Director of Nursing) stated she expects staff to provide privacy to resident when exposing resident's private parts by covering their private areas with a cover or closing the window shades. V2 stated that this is done to show the resident respect and maintain his privacy, and to protect his dignity and one wants to be exposed. The facility's member rights policy revised September 2025 showed the following: "it is the philosophy and policy of the Illinois Veteran's Home at Manteno (IVHM) to treat all members in	S9999		

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S9999	Continued From page 7 the least restrictive and most dignified manner possible." (B) 4 of 6 340.1570a)1) Section 340.1570 Personal Care a) Personal care, as defined in Section 340.1000, shall be provided on a 24-hour, seven-day-a-week basis, as needed by the resident. This shall include, but not be limited to, the following: 1) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to any treatment ordered by the physician. This requirement is not met as evidence by: Based on observation, interview, and record review, the facility failed to provide perineum and indwelling urinary catheter care for residents who require assistance with activities of daily living (ADL) care. This failure applies to 2 of 2 residents (R7, R9) reviewed for personal care in a total sample of 9 residents. The findings include: 1. Face sheet shows that R7 is 72 years-old who has multiple medical diagnoses including Multiple Sclerosis and neuromuscular dysfunction of the bladder.	S9999		

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S9999	Continued From page 8 R7's ADL Care Plan shows R7 has an indwelling urinary catheter, he is incontinent of bowel and requires extensive assistance to total dependence with perineum and catheter care. R7's Physician Order Summary (POS) shows: Catheter care every shift and as needed. On October 8, 2025, at 10:00 AM, R7 was resting in bed with an indwelling urinary catheter. R7's brief was dry, however, there was a strong urine odor coming from R7. V10 (Nurse) applied Zinc Sulfate ointment to R7 from back to front of his perineum, and then V8 and V9 (Both Certified Nursing assistants/CNA) assisted R7 to change his incontinence brief without providing perineum and urinary catheter care. V8 stated that R7's brief was last changed by night shift between 6AM to 7AM. On October 8, 2025, at 1:47 PM, V17 (Infection Preventionist) stated the staff are to provide peri-care prior to changing incontinence brief and before they apply any ointment. The staff must provide catheter care if the resident has an indwelling urinary catheter. They should also apply ointment from front to back of the perineum to prevent cross contamination and potential infection. 2. R9's admission record showed R9 was admitted to the facility with diagnoses that included morbid severe obesity due to excess calories, heart failure, chronic obstructive pulmonary disease and osteomyelitis of vertebra, sacral and sacrococcygeal region. R9's care plan showed the following: R9 has activities of daily living performance deficit related	S9999		

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S9999	Continued From page 9 to obesity, stage 4 sacral ulcer, atrial fibrillation, chronic obstructive pulmonary disease, oxygen dependence, impaired balance and shortness of breath. R9 required extensive to dependent assistance by 1-2 staff with bed mobility and showering. On October 8, 2025 at 11:02 AM, during observation of wound care for R9, V12 and V13 (Certified Nursing Assistant/CNA) removed a brown stained sheet from R9's lower body. V13 then held R9's to the side for V12 to treat R9's stage 4 coccyx wound. R9 has a stage 4 wound to his coccyx and the surrounding was red and excoriation with flaky dry patches that extended from the inner buttocks to the middle of the buttocks and then down the entire buttocks and about 6 inches down his upper and inner thighs. The reddened areas of R9's skin had crumbly dried pink zinc barrier R9 screamed throughout wound care and positioning. V12 and V13 did not clean R9's red flaky dry excoriated skin at any time during the wound care. On October 8, 2025 at 2:00 PM, V2 (Director of Nursing) stated she expects her staff to clean areas that are dirty and areas that need cleaning on a resident, while the area is exposed because it would cut down on bacteria, and to protect resident's skin. (B) 5 of 6 340.1640c) Section 340.1640 Vaccinations c) A facility shall provide or arrange for	S9999		

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S9999	Continued From page 10 administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination, or the vaccination is medically contraindicated. (Section 2-213(b) of the Act) This requirement is not met as evidence by: Based on observation, interview, and record review, the facility failed to provide pneumococcal vaccination as required. This failure applies to 1 of 5 residents (R7) reviewed for vaccinations in a sample of 9 residents. The findings include: 1. Face sheet shows that R7 is 72 years-old with multiple medical diagnoses including Multiple Sclerosis. R7 was admitted to the facility on April 9, 2018. R7's vaccination log showed that he received a pneumonia vaccine on September 1, 2017, at the age of 64. However, it is not known what type of pneumonia vaccine he received. There was no further documented follow up or recommendation for R7's pneumonia vaccination. On October 8, 2025, at 1:38 PM, V17 (Infection Preventionist) stated that upon admission they check the vaccination history of the resident. If the resident is non-interviewable, they check with the family. If a resident refused pneumonia	S9999		

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S9999	Continued From page 11 vaccine they still need to follow up and re-offer yearly, ensure that this vaccine is being offered accordingly, and document if the resident received it or refused. The required pneumonia vaccine is the PCV20 or PPSV23 The facility's policy and procedure for immunization, which was formulated on September 22, 2022 states in part: "Policy: All residents of this facility will be screened for the following vaccine preventable diseases: Pneumococcal, Influenza, Tetanus, Diphtheria, Pertussis, shingles, and Hepatitis B. If the vaccine is not available from the transferring facility, from the family, or Power of Attorney (POA) and cannot be found in the Comprehensive Automated Immunization registry (ICARE), attempts will be made by the adjutant, admission officer, or the unit nurse during admission to gather this information from the previous medical provider. If no vaccine history can be ascertained, the resident will be vaccinated according to the following schedule. If the resident, family or POA refuse vaccines, advise that infection prevention measures may need to be taken in the event of community illness or outbreak." "Pneumococcal Vaccine: Upon admission to the facility, resident 65 years and older must be assessed for pneumococcal vaccine status. If it's not been given, a consent must be obtained from the resident or responsible party to administer pneumococcal vaccine (year-round) as directed unless contraindicated." "a. Resident without proof of previous pneumococcal vaccination should receive a pneumococcal vaccine. Examples of	S9999		

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S9999	Continued From page 12 pneumococcal conjugate vaccines include PCV13, PCV15, and PCV20. PPSV23 is a pneumococcal polysaccharide vaccine. If PCV20 is used, their pneumococcal vaccinations are complete. If PCV15 is used, follow with one dose of PPSV23. The recommended interval is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak." "b. Resident who has previously received PPSV23 and not received any pneumococcal conjugate vaccine (PCV13, PCV15, or PCV20), may have the PCV15 or PCV20. The minimum interval is 1 year." (B) 6 of 6 340.1950a) Section 340.1950 Food Preparation and Service a) Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). The REQUIREMENT was not met as evidenced by: Based on observation, interview, the facility failed to ensure that food employees wore, beard restraints to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. This applies to all 205 residents who receive food from the kitchen.	S9999		

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S9999	Continued From page 13 Findings include: On October 7, 2025 at 9:53 AM, V16 (Cook 1) who has a beard that was at least 4 inches long and mustache was preparing broccoli in the kitchen without wearing a beard guard/net/covering. On October 7, 2025 at 10:13 AM, V16 was preparing ham and beans for lunch in the kitchen without wearing a beard guard/net/covering. On October 7, 2025 at 10:20 AM, V15 who has a beard and mustache was prepping chili with no beard or net/cover. On October 7, 2025 at 10:54 AM, V15 was prepping cooked muffins for service without wearing a beard guard/net/covering. On October 8, 2025 at 9:54 AM, V16 was grilling beef patties for lunch and was not wearing a beard guard/net/covering. On October 8, 2025 at 2:37 PM, V14 (Adjutant) and manager of dietary stated it is her expectation for the kitchen staff to have beard coverings while in the kitchen and when cooking. V14 stated she expects staff to wear a beard and hair covering to protect food from being contaminated from hair and hair dander. The facility's Hair Restraints/Jewelry/Nail Polish/False Eyelashes policy showed the following: Food and nutrition employees shall wear hair restraints and beard guards. Hairnets will be worn at all times in the kitchen. Beard guards or masks will be worn as indicated. The facility's beard guards poster that is outside of the kitchen along with beard guards and hair nets showed "Beard guards are not an option. It is a	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014948	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/09/2025
NAME OF PROVIDER OR SUPPLIER ILLINOIS VETERANS HOME AT MANTENO			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
S9999	Continued From page 14 requirement just like hairnets!" The poster then showed all kinds of facial hair options. (C)	S9999			