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 _____	07/19/2013

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

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Z 000	COMMENTS Investigation of Incident Report Investigation of 7/6/13.	Z 000		
Z9999	FINDINGS Licensure Violations: 340.1310d) 340.1440f) 340.1505b) 340.1505d)3) 340.1505g) 340.1310 Admission, Retention and Discharge Policies d) Residents with a history of aggressive or self-abusive behavior may be admitted only if the facility has in place appropriate, effective and individualized programs to manage the resident's behaviors and adequate, properly trained and supervised staff to administer the programs. 340.1440 Abuse and Neglect f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other resident and employees of the facility. 340.1505 Medical, Nursing, and Restorative Services	Z9999		

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Z9999	Continued From page 1 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. d) Pursuant to subsection (a), general nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 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. These requirements are not met as evidenced by: Based on record review and interview the facility failed to supervise and monitor 1 resident (R2) in a manner to prevent R2 from becoming physically aggressive and seriously injuring another resident (R1) on 7/6/13. As a result of this failure R1 was sent to a nearby	Z9999		

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hospital where he was diagnosed with an intracranial hemorrhage/subdural hematoma with midline shift. R1 expired at the hospital on 7/8/13 (2 days later).

This is for 2 of 3 residents reviewed for safety/supervision (R1 and R2) in the sample of 3.

The findings include:

Review of R2's admission face sheet showed R2 was admitted to the facility on 7/29/10 with diagnoses which included Brain Anomaly with Ventricular Shunt, Alcohol Mental Disorder and Panic Disorder. The initial progress note from social services dated 7/29/10 also showed R2 had history of being easily agitated, anxious, and having panic attacks.

Review of R2's nurses notes, physician's notes, social service notes, and hospital records from August 2010 to July 2013 showed numerous incidents where R2 exhibited agitated, and verbal and physically aggressive behaviors.

Hospital documentation from Sept. 2012 to July 2013 regarding R2's hospitalizations showed 5 aggressive episodes prior to 7/6/13.

9/6 - 9/12/12 - Aggressive behavior - Hitting staff member and attacking a resident.

12/9 - 12/14/12 - Aggressive behavior - Incident of aggressive behavior with another resident.

1/6/13 - 1/11/13 - Aggressive behavior. (Per hospital discharge summary 1/11/13) Resident admitted due to aggressive behavior. Puts himself and others in dangerous situations.

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Z9999	Continued From page 3 4/4/13 - 4/9/13 - Aggressive behavior. Attacked 2 residents. (Per psych history dated 4/4/13) Res. states, "Unable to control sometimes." Very impulsive. 4/24/13 - 4/30/13 - Aggressive - Had fight with 2 residents. Attacked 2 residents. (Per psych progress note dated 4/24/13) "Resident with very nasty personality. We are very concerned about his behavior and safety issues." 7/6/13 - Severe aggression. Struck another resident at facility. Other resident passed away. Social Service documentation dated 5/4/13 regarding R2 showed, "Can be demanding and argumentive, occasionally refused care and curses at staff. Member (R2) has had further episodes of striking other members on 4/3, 4/4, and 4/23/13. Was admitted to hospital psych 4/4 - 4/9/13 and again 4/24-4/30/13. On 3/23/13 R2 raised his fist to another member but staff able to intervene in time. Member (R2) now on 1:1 staffing until hopefully he can be transferred out for further mental health care." An incident report and nursing documentation showed R2 had 4 physically aggressive incidents in the smoking rooms of the facility without having staff supervision. An incident report dated 8/3/12 at 3:35 p.m. showed R2 and R6 were in a facility smoking room. Upon staff entering the room R2 was observed out of his wheel chair hitting R6. An incident report dated 1/6/13 at 1:25 p.m. showed R2 and R7 were in the 2 West facility smoking room when R2 slapped R7 to the left	Z9999		

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side of R7's face. R2 was sent to a nearby hospital to be evaluated for aggressive behavior.

An incident report and nursing documentation dated 4/23/13 showed on 4/23/13 at 7:25 p.m. R2 was in the smoking room with R5. Staff heard raised voices and swearing, entered the smoking room, and found R5 bleeding from his lower lip. R5 stated he asked R2 to move a bit to get to a puzzle. R2 then hit R5 two times in the mouth.

The incident report dated 7/6/13 showed at 6:10 a.m. R2 was again in a facility smoking room on unit 4 West with R1. Staff heard shouting coming from the smoking room and upon entering the room found R2 hitting R1. R1 told staff, "R2 hit me in the face about 2-3 times." R1 was sent to a nearby hospital where he had a CT (computerized tomography) scan of the brain and was diagnosed with a large subdural hematoma with midline shift. R1 expired on the morning of 7/8/13.

During each of these incidents R2 was not supervised in the smoking rooms.

On 7/9/13 between 6:25 p.m. - 7:30 p.m. E1(Administrator) and E2 (Director of Nurses) said R2 had been on 1:1 supervision previously and the 1:1 had been discontinued as of 5/24/13 due to R2 not having aggressive behaviors. But, a review of a social service note dated 5/17/13 at 2:42 p.m. notes "per E1 (Administrator) Involuntary Discharge proceedings could take place if R2 strikes at anyone else."

Nursing documentation shows on 5/24/13, R2's 1:1 supervision had been discontinued and R2 was placed on every 30 minute monitoring. Further review of nursing documentation showed

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R2's aggressive behavior was escalating. The nursing documentation showed:

5/28/13 12:03 p.m. Was told by VNAC when R2 was going into his room, room mate was in his way. R2 said to room mate "move you Mother F---ker."

6/3/13 10:22 a.m. R2 came up to desk requesting a cigarette. Was told he just had one. He replied, "F--k you. I did not."

6/23/13 1:38 p.m. R2 sitting at the nurses station and asked for a cigarette. I (nurse) told R2 no, he has 25 more minutes. He told me, "F--k you!"

6/24/13 10:32 p.m. VNAC(Veteran Nurse Aide Certified) was trying to change R2 and he refused care. VNAC encouraged R2 to clean up because he was wet and he continued to refuse and started to get angry so VNAC backed away. R2 in bed with wet attends.

7/3/13 12:06 p.m. R2 came up to nurse stated, "cigarette!" I told him to wait a second because I was in the middle of doing charting. He replied, "F--k you. I am going to kick your a-s and you can't stop me." MD notified.

7/6/13 6:10 a.m. Staff heard shouting from smoking room, upon entering found R2 and R1 in room. R1 stated R2 hit him in the face about 25 times. Both residents were sent out to nearby hospitals for evaluation and treatment. R1 was found with an large subdural hematoma with midline shift and expired on 7/8/13.

Interviews with E4 (RN) and E5 (VNAC) on 7/10/13 between 11:45 a.m. and 12:30 p.m. and E6 (VNAC) on 7/11/13 at 10:40 a.m. verified the

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incident on 7/6/13 when R2 attacked R1 striking R1 in the face.

On 7/10/13 at 1:30 p.m. Z1 (MD) said, "R2 has very impulsive behavior. He goes from calm to explosive very quickly. On the day before the incident the resident became very agitated with the nurse. The nurse called me and said R2 was cursing and agitated. Every couple of weeks we get a call about R2 hitting someone. He will pick on anyone who comes his way. He has extremely impulsive behavior. He is always the one who throws the punch."

On 7/11/3 at 1:45 p.m. Z3 (Psychiatrist) said, "I've treated R2 many times. He has diagnoses of Bipolar, Antisocial, and Agitated behavior. He's aggressive and agitated. When he doesn't get his way he tends to strike. Maybe he should have been re-evaluated with the threat to the nurse. I can't say he didn't need 1:1 supervision."

On 7/9/13 at 6:45 p.m. E1 (Administrator) and on 7/10/13 at 4:30 p.m. E2 (Director of Nurses) were asked why R2 had not been placed back on 1:1 supervision since he was exhibiting escalating aggressive behavior. E1 and E2 were also asked what criteria is used to place a resident on 1:1 supervision.

E1 and E2 stated that R2 had not exhibited any aggressive behavior from 5/24/13 until the date of 7/6/13 and both stated they have no policy or criteria in place to identify when a resident is to be placed on 1:1 supervision. Both stated the IDT (Interdisciplinary team) along with the doctor meets and discusses when a resident should be placed on 1:1 supervision. E2 mentioned the cost of 1:1 supervision saying, "It costs a lot to have staff here to provide 1:1 supervision to R2."

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Z9999	Continued From page 7 On 7/11/13 at 2:20 p.m., E3 (Assistant Director of Nurses) said, "We do not have a policy/procedure on placing residents on 1:1 supervision. We use nursing judgement and call the doctor for an order". Nursing documentation from Sept. 2012 to July 2013 showed there was no documentation or analysis identifying that R2 needed supervision while in the smoking room. There was also no analysis identifying that R2's aggressive behaviors were escalating and that R2 needed closer supervision. R1's physician's orders of 7/2013 and his hospital history and physical dated 7/6/13 showed R1 had orders and was receiving Plavix 75 mg per day and Aspirin 81 mg per day as anticoagulant therapy leaving R1 at a higher risk for bleeding. R1's plan of care showed R1's plan of care did not address R1's anticoagulant therapy. R2's plan of care addressing R2's aggressive behaviors showed that R2's 1:1 supervision had been discontinued on 5/24/13. No other interventions (monitoring every 30 minutes, monitoring R2 while in smoking room, etc...) was not addressed on R2's care plan. (A)	Z9999		