STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015481	A. BUILDING: _____ B. WING _____	C 03/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT LASALLE	1015 O'CONNOR AVENUE LA SALLE, IL 61301

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S 000	Initial Comments Facility Reported Incident Investigation to Incident date of 3/15/21/Il 132031- 340.1300 a), 340.144 a, b, and e Original Complaint Investigation #2121819/IL131885	S 000		
S1440	Section 340.1440 Abuse and Neglect This Regulation is not met as evidenced by: Statement of Licensure Violations: 340.1300 a) 340.1440 a) 340.1440 b) 340.1440 e) Section 340.1300 Facility Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated with the involvement of the administrator. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the facility's advising physician or the medical advisory committee, as evidenced by a dated signature. 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	S1440	Attachment A Statement of Licensure Violations	

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S1440	Continued From page 1 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 employee. (Section 3-611 of the Act) Based on interview and record review, the facility failed to prevent abuse, failed to report potential abuse immediately, failed to immediately remove the staff member from contact with residents after a report of potential abuse, and failed to follow their policy to immediately examine a resident and immediately suspend the accused staff member after a report of potential abuse for two (R1 and R2) of three residents reviewed for abuse in a sample of six. This has the potential to affect all 30 residents (R1, R3, R7-R34) living on the East Wing at the time of the reported incident. Findings include: Facility "Abuse Prohibition, Abuse and Neglect, Involuntary Seclusion, Misappropriation of Resident Property, and Injuries of unknown source," dated 10/1/2007, documents "(Nursing home) affirms that all residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Abuse means any physical or mental injury or sexual assault inflicted on a resident other than by accidental means. Procedure for	S1440		

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S1440	Continued From page 2 reporting alleged abuse or neglect: Any employee who becomes aware of suspected abuse or neglect should immediately inform the Team Leader on duty without fear of retribution. The facility employee or agent who becomes aware of alleged abuse or neglect of a resident should report the matter to the facility administrator or designee. When the Team Leader is made aware of any allegation of abuse or neglect concerning any resident they shall immediately examine the resident involved to determine whether the resident is in any distress or has suffered any injury. The nurse shall take all the steps necessary to protect the resident from danger. If the incident involves suspected abuse, then the Team Leader shall assure that the suspected abuser has no further contact with the resident involved or with any other resident. Abuse and Neglect: Residents are not to be subjected to abuse by anyone including facility staff. Procedure-Protection/Response: The person alleged to have abused a resident will immediately be suspended pending investigation." Facility Staffing Sheets, dated 3/15/21, documents V10 Registered Nurse/RN, V4/RN, V3 Veterans Nursing Assistant Certified/VNAC, and V9/VNAC were all scheduled to work East Wing from 3pm-11pm. 1. R1's Initial Incident Report to IDPH-Allegation of Abuse, dated 3/16/21, documents Physical Abuse by V3/VNAC regarding R1 "On 3/16/21, VNAC (V9) reported to their Union Representative (V12) that prior evening (3/15/21) during cares resident (R1) bit another caregiver (V3) and caregiver (V3) reacted by "slapping" resident in the forehead."	S1440		

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S1440	Continued From page 3 R1's Unusual Occurrence/Incident Report, dated 3/16/21 at 11:31am by V9/VNAC, documents that on 3/15/21 abuse to R1's head by V3/VNAC occurred with no injury observed to R1's head. It further documents that while putting R1 to bed, R1 went to bite V3 and V3 pulled away and smacked R1 in the forehead. R1's MDS (Minimum Data Set), dated 1/31/21, documents R1 is severely cognitively impaired. R1's medical record has no documentation a body assessment or any type of assessment was performed on 3/15/21 after the alleged incident. On 3/25/21 at 9:35am, V2, Director of Nursing (DON), stated "I am performing the Incident Investigation regarding (V3) VNAC and (R1) from (3/15/21). I sent the initial report in on 3/16/21 regarding the incident on 3/15/21 because we were not notified until 3/16/21 in the morning. We are not done investigating so I do not have a final report because we were told by the state police they were taking over the investigation. The state police will be here today, (V10) RN and (V3) VNAC were put off work immediately after we were notified on (3/16/21) for failure to report an allegation of abuse right away. (V10) RN has since come back but (V3) VNAC remains off work on paid status pending the investigation. I was not notified right away, (V3) VNAC finished out her 3pm-11pm shift on 3/15/21 so she had access to the residents and was not removed from the residents because I did not know about it. (V9) and (V3) both VNAC's were in (R1's) room and provided incontinence cares to (R1). (V9) VNAC reported that during the cares with (R1) (V3) hit (R1) on the forehead after (R1) punched and bit (V3). (V9) VNAC reported the incident to (V4) RN and (V4) told (V9) she needed to report the	S1440		

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S1440	Continued From page 4	S1440		

incident to (V10) RN who was (R1's) nurse for the night. (V9) did not report the incident to (V10) but we were not aware of that when we initially put (V10) off work. We were not notified of the incident with (R1) until 3/16/21 (the next day) so no assessment was done on (R1) for 3/15/21. Nursing performed a body assessment on (R1) on 3/16/21 and nothing was found. I should have been called and notified, staff and residents should have been separated, but that wasn't done, no assessment was done until we knew about it the next day. (V9) texted her union rep (V12) union representative on 3/16/21 that she reported abuse to (V4) on 3/15/21 and nothing was done about it. I was notified by (V12) as soon as he found out and then we started the investigation. We are all the abuse coordinators which includes the Administrator and the rest of management. We have given the staff training on abuse."

On 3/25/21 at 12:45 pm, V3/VNAC stated, "Last Tuesday (3/16/21) I came to work and was met at the door and told to go home because of an allegation of abuse from Monday (3/15/21). (V9) VNAC and I worked together on 3/15/21 with (R1). I finished out my shift on 3/15/21, I work 3-11pm, and I walked out with the rest of the staff."

On 3/25/21 at 2:00pm, V4/RN stated, "There was an incident last week (3/15/21) where I was working. I was in the medication room about 10 pm, (V9) went into the med room where I was and (V9) told and demonstrated with her fingers to me that (V3) put her fingertips to (R1's) forehead. I told (V9) that she needed to report the incident to (V10) RN who was (R1's) nurse. I did not go see or perform a skin assessment on (R1) because (V10) was (R1's) nurse for the night, so I

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S1440	Continued From page 5 told (V9) that she needed to report it to (V10) so she could do the process for abuse. Our abuse coordinators are the Director of Nursing or Administrator. I should have reported it to our shift coordinator, but I did not. I have had training on abuse. We all walked out together at the end of our shift." On 3/25/21 at 10:21am, V10, RN, stated, "On 3/15/21 about 10 pm I heard (V3) VNAC talking at the nurses desk while she was charting, I heard her say to the other VNACs that (R1) was combative and attempted to bite her during cares, the VNAC's were all laughing about it as they walked out the door, and the mood was light with the staff. I did not know there was any concern about abuse. About 10 am the next day (3/16/21), I was notified by (V4) RN that she told (V9) VNAC to talk to me about the concerns (V9) had about (V3), but she did not report anything to me. I did not call to report anything because (V4) said (V9) was calling the nursing home to report it. I did not assess (R1) because I did not know about any potential abuse concerns. We have had in services on abuse and I know our abuse coordinators are management." 2. R2's Abuse report, dated 7/17/20, documents R2's "Allegation of mental abuse is substantiated by resident interview." R2's initial abuse report, dated 7/10/20, documents "(R2) reported to another VNAC that he felt uncomfortable with (V6) VNAC providing care. VNAC reported this to her supervisor. (R2) was interviewed by Director of Nursing and Supervisor and reiterated his discomfort with VNAC (V6) stating he is "mean." At the time of R2's abuse report, R2's MDS,	S1440		

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S1440	Continued From page 6 dated 6/23/20, documents R2 was cognitively intact. V6's employee file was reviewed and V6 was put on administrative leave on 7/10/20 and terminated on 8/4/20. On 3/25/21 at 11:40 am, V2, DON, stated "(V6) VNAC was fired after he was off on administrative leave due to the incident with (R2) where mental abuse was substantiated." (B)	S1440		