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 _____	09/13/2023

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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 340.1900 e) 340.1950 a) Section 340.1900 Food Service Staff e) Food service personnel shall be in good health and shall practice hygienic food handling techniques and good personal grooming. 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). These REQUIREMENTS are not met as evidenced by: Based on observation, interview, and record review, the facility failed to change gloves and perform hand hygiene during meal service preparation and failed to ensure food was covered while being transported throughout the facility. This failure has the potential to affect all 87 residents who currently reside in the facility except R5 who is NPO (Nothing by Mouth). Findings include: The facility's "Handwashing" Dietary Policy, dated 6/1/14, states, "To ensure proper sanitation safety	S9999	Attachment A Statement of Licensure Violations	

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of the Dietary Department employees when preparing and or serving the residents meals and or snacks. This same policy documents employees will wash their hands after touching their hair, face, or any other body part. "4. Employees will wear gloves while preparing or serving any food item to avoid direct contact with food items in order to avoid any cross contamination. 5. Gloves will be changed frequently and especially when employees are switching from one food item to another, from dirty to clean dish handling, or from chemicals or cleaning agents to foods, etc."

The facility's "Personal Hygiene-Dietary Employees" Policy, dated 6/1/20, documents gloves must be worn when in contact with food. This same policy documents gloves should be changed frequently throughout tasks to avoid cross-contamination and promote good safety habits.

On 9/12/23 at 11:45 AM, V6 (Cook II) washed hands and put on a pair of gloves. V6 then began checking temperatures of the lunch meal in the kitchen. V6 handled the thermometer, alcohol wipes, the temperature food log, and an ink pen to record the obtained food temperatures. After temperatures were taken and without handwashing or any glove changes, V6 began plating lunch meal trays for the memory care unit residents. During the meal tray preparation, V6 swiped across V6's forehead with V6's gloved left hand. On 9/12/23 at 11:53 AM, without handwashing or any glove changes, V6 opened a package of hamburger buns and removed three buns out of the packaging, directly touching the buns with V6's same gloved hand.

On 9/12/23 at 12:02 PM, V6 removed V6's soiled

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gloves, washed hands, and placed on a new pair of gloves. V6 then pushed a warming cart out of the kitchen for transportation to the East Wing. Once on the East Wing and while wearing the same pair of gloves, V6 plugged the warming cart into a wall outlet, checked and logged food temperatures of the lunch meal and then began plating the residents' lunch meal trays. On 9/12/23 between 12:17 PM-12:23, V6 was observed to have done the following without handwashing and while wearing the same pair of gloves: opened foil wrap which contained two corn dogs; touched the corn dogs directly with V6's gloved hand and placed them on a plate; opened a package of hamburger buns and removed buns directly with V6's soiled gloves and placed them on a plate; swiped loose hairs behind V6's left ear with V6's left gloved hand; unplugged the warming cart from the outlet; and pushed the warming cart through the hallways back into the kitchen without covering the leftover food with lids. On 9/12/23 at 12:27 PM, once back into the kitchen, V14 (Sanitation Safety Worker) approached V6 asking for a food tray for R8. Without removing V6's same soiled gloves or performing hand washing, V6 plated a lunch tray for R8. To create more space on the lunch tray for more food, V6 pushed R8's portion of mixed vegetables over to side directly with V6's right thumb, while wearing the same pair of soiled gloves. No handwashing or glove changes occurred throughout.

On 9/12/23 at 12:30 PM, V6 verified V6 did not change gloves or perform hand hygiene during the lunch meal preparation before directly touching food items or after touching V6's hair/face. V6 stated, "I should have." At this time, V6 also verified V6 served R8 food that was transported throughout the facility without being

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covered. V6 stated V6 should have covered the food before leaving the dining area.

On 9/13/23 at 10:38 AM, V5 (Dietary Manager) stated V6 should not have touched food directly with V6's soiled gloves and V6 should not have transported residents' food throughout the facility without a covering. V5 stated the dietary staff was just re-educated on all this a couple months ago. V5 stated, "They know better."

The Resident Census and Conditions of Residents, signed and dated by V12 (Minimum Data Set Assessment Coordinator) on 9/12/23 documents 87 residents currently reside in the facility.

(C)
2 of 2

340.1300 a)
340.1505 g)

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 340.1505 Medical, Nursing and Restorative Services
g) All necessary precautions shall be taken to assure that the resident's environment remains as free of accident hazards as possible. All

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nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to ensure one confused, independently ambulatory resident with dementia (R6) was wearing appropriate footwear of two residents reviewed for falls in a sample of eight. This failure resulted in R6 suffering from a subdural hematoma, staples to R6's head, and a nasal fracture.

Findings include:

The facility's Falls policy, dated 5/9/19, documents "Policy: It is the policy of this facility that all residents reside in a safe environment. All steps will be taken to protect the resident from falls and injury."

R6's current Physician Order Sheet/POS documents R6 has diagnoses including Dementia and Traumatic Subdural Hemorrhage.

R6's Minimum Data Set/MDS assessment, dated 6/20/23, documents R6 is moderately cognitively impaired, requires extensive assist with one person physical assist for dressing, and is independent without physical help from staff for locomotion on the unit.

R6's current Care Plan documents R6 is at risk for falls and includes interventions of "Ensure that the resident is wearing appropriate footwear when ambulating. Date Initiated: 10/03/2018" and "Review information on past falls and attempt to determine cause of falls. Record possible root

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causes. Alter/remove any potential causes if possible."

R6's Progress Note, dated 8/20/23, documents "At (9:00pm), resident observed lying on the floor, in the dining area close to the TV. Head leaning on the linen hamper. Small amount of blood from his head noted."

R6's "Fall Occurrence Report Investigation," undated, documents R6's fall on 8/20/23 resulted in a 2 cm (centimeter) laceration on the back of R6's head.

R6's Follow-up report to incident sent to State Agency on 8/20/23, dated 8/24/23, documents "Description of Incident: On Sunday August 20, 2023, at 9pm (R6) was observed on the floor in the (named memory care unit) dining room near the TV with his head resting on a linen hamper." This report also includes "Environmental assessment revealed: The floor was dry and lighting was adequate. Resident was ambulating independently. Resident was wearing shoes and non-skid socks, shoes noted to be ill-fitting." This report also documents conclusions that include "Resident did not have shoes that fit appropriately."

R6's "CT (Computed tomography) Head or Brain without contrast Impression: 1. Small thin subdural hemorrhage along the falx without mass effect and a maximal thickness of 5mm (millimeters)" and "4. Stapled scalp laceration at the posterior convexity."

The facility's "Witness Narrative Statement," dated 8/20/23, by V8, Veteran Nurse Assistant Certified/VNAC, documents R6 fell while walking toward the dining room wearing shoes that were

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too big for him.

On 9/12/23, at 11:15am and 2:50pm, R6 was independently ambulating in the hallway and dining area of the locked memory care unit with soled slippers on his feet.

On 9/13/23, at 8:55am, R6 was independently ambulating from the dining room back to his room wearing non-skid socks.

On 9/12/23, at 2:57pm, V8, VNAC, stated the following: V8 was assisting another resident when (V7) called out and said someone fell and it was R6. "(R6) was flat on his back. There were no witnesses. (R6) ambulates independently all day every day. Not sure why he fell. (R6) had on a pair of camouflage slip on shoes on, but they were quite a bit too big for him. I took his shoes off and put them in his room before he left (for hospital)."

On 9/12/23, at 3:00pm V8 opened a cabinet drawer in R6's room that held a pair of camouflage slip on shoes and two other smaller pairs of slip ons.

The facility's "Witness Narrative Statement,", dated 8/20/23, by V16, VNAC, documents R6 said he fell, and R6 was wearing shoes that are too big for him.

On 9/12/23, at 3:43pm, V16 was unavailable for interview.

The facility's "Fall Communication Slip", dated 8/20/23 and signed by V7, RN/Regsitered Nurse, documents "New Interventions: Need new pair of shoes. His shoes are too big for him. They are not the right size."

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S9999	Continued From page 7 On 9/13/23, at 7:25am, V7 Registered Nurse/RN stated the following: "I was passing meds (medications). I glanced over at the TV room from the med room since that is where they congregate and saw (R6) on the floor by the dining room. I assessed him. He was wearing shoes and non-skid socks, but the shoes at that time were bigger. Maybe he got out of balance. He needs help getting dressed. We reported that he needs appropriate sized shoes. They probably got rid of those big shoes. I'm pretty sure." The facility's "Five Whys Template," undated and unsigned, documents "Root Cause: shoes not right size." On 9/13/23, at 8:50am, V9, VNAC, stated the following: "(R6) is a limited assist of one. He can help but doesn't. He can put his shoes on, but we help him because he'll just slide them on with the backs down. He just steps into them and doesn't fix the backs of them." On 9/13/23, at 8:53am, V10, VNAC, stated, "(R6) needs help with getting dressed and is completely dependent. I hand him a shirt for him to put on and I'll do the bottoms. He'd rather wear slipper socks. He needs help if he wears shoes." On 9/13/23, at 8:58am, V11, VNAC, stated, "(R6) is a one assist to get washed up and dressed including his shoes. Usually when I get him ready he won't put shoes on so I put non-skid socks on." On 9/13/23, at 12:40pm, V2, Director of Nursing/DON, stated, "It may have been his shoes that caused (R6's) fall." V2 confirmed at this time, the facility's "Five Whys Template"	S9999		

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documents the root cause as R6's shoes being too big. V2 stated R6's ill-fitting shoes should have been removed from his room. V2 stated that she was unaware R6's shoes were still in his room.

On 9/13/23, at 12:53pm, V15, RN Dementia Care Supervisor, stated the following: "(R6) requires extensive assist for dressing his lower extremities with physical help. He won't help a lot of the times. He can put shoes on, but not fully on and appropriately so we must help him. Root cause was multiple factors including his shoes being too big which may have had something to do with his loss of balance." V15 continued with "(R6's) shoes were taken out of use pending receiving a new pair. Then we would throw them out."

On 9/13/23, at 1:02pm, R6 sat in a recliner in his room. At this time, V15 opened R6's cabinet drawer where R6's large camouflage shoes were sitting. R6 stated the girls help R6 with his shoes if he needs them. V15 stated, "I ordered his new ones that he is wearing. I put them on a request list then Social Services buys them. I don't know when he got them. I will remove the big shoes now." V15 confirmed since the large shoes were left in R6's room, they could have been put on his feet again.

(A)