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 04/18/2024

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

(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 Complaint Investigation 2422636/IL171533	S 000		
S9999	Final Observations Statement of Licensure Violations: 340.1300 a) 340.1440 a) 340.1440 c) 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) c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative. (Section 3-610 of the Act) These requirement are not met as evidenced by: Based on interview and record review, the facility failed to identify verbal abuse for one of five resident (R1) reviewed for abuse in a sample of	S9999		

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S9999	Continued From page 1	S9999		

Continued From page 1

five.

Findings include:

The facility's Abuse prohibition, Abuse and neglect, Involuntary Seclusion, Misappropriation of Resident Property and Injuries of Unknown Source Policy, dated June 2021, documents Verbal abuse means the use by an employee or agent of oral, written or gestured language that includes disparaging and derogatory terms to a resident or their families, within his or her hearing or seeing distance, regardless of the reside's age, ability to comprehend or disability. It includes staff yelling, swearing, gesturing or calling an individual a derogatory name as well. Name calling, use of obscenities and/or staff using threatening language. This form documents an employee as perpetrator of abuse: When an investigation of a report of abuse of a resident indicates, based upon credible evidence, that an employee a long-term care facility is the perpetration 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. If allegation is substantiated, the employee will be terminated.

V4's Unusual Occurrence/Incident Report, dated 2/20/24, documents she gave R5 a cup of pills and asked him to take the pills. R5 proceeded to call her a b**ch; V4 documented she inappropriately responded he was a "B**ch" by throwing his pills on the floor.

V9, Health Pro, signed interview dated 2/20/24, documents she was in the television room working with a resident. V9 overheard V4 say, "Let me see you (R5) finish thouse pills before

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S9999	Continued From page 2	S9999		

you go. I heard (R5) call her a B**ch and the pills hit the floor. (V4) came back with saying your a b**ch for throwing your pills on the floor."

V6, Veterans Nursing Assistant, signed interview dated 2/20/24, documents, "(R5) threw his pills and called (V4) a b**ch. (V4) said your the b**ch for not taking your them. (V4) knew when she said it, it was wrong. (V5) told (V4) to watch her mouth."

The facility's Description of Incident, dated 2/26/24, documents V4 self reported the incident. V4 reported R5 called her a b**ch and she responded, "You're a b**ch for throwing your Pills." This form documents V4 has an emotional response.

On 4/18/24 at 10:00am, V5, Veterans Nursing Assistant, Certified, stated she was at the nurses station and heard V4, Registered Nurse, offer R5 his medications. R5 threw the medications on the floor and called V4 a b**ch. V5 stated V4 picked up the pills and told R5 he was a B**ch for throwing the pills. V5 stated she immediately yelled out to V4, and told her she could not speak like that. V5 stated she told V4 to go back to the desk, and R5 went down the hall to his room. V5 stated she spoke with V4 and asked her to go to V1, Administrator, herself. V5 stated she did, then was escorted out of the building. V5 stated this was very inappropriate, and has never heard anything like that.

On 4/18/24 at 11:30am, V1, Administrator, stated V4's actions were not intentional, so the incident was not considered verbal abuse.

(B)

Illinois Department of Public Health

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