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 08/17/2025

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 Investigation of Facility Reported Incident of 7/16/25, IL 196877.	S 000		
S9999	Final Observations Statement of Licensure Violations: 340.1300 a) 340.1330 c) 340.1440 d) 340.1440 f) 340.1505 b) 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 340.1330 Incidents and Accidents c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 340.1380, notify the Regional Office by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is	S9999		

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S9999	Continued From page 1	S9999		

unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence.

Section 340.1440 Abuse and Neglect
d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)
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 residents and employees of the facility. (Section 3-612 of the Act)

Section 340.1505 Medical, Nursing and Restorative Services
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.

THESE REQUIREMENTS ARE NOT MET AS EVIDENCED BY:

Based on observation, interview, and record review, the facility failed to implement abuse

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S9999	Continued From page 2	S9999		

interventions to prevent resident to resident physical abuse, and failed to report and investigate an allegation of verbal abuse for one of three residents (R1) reviewed for abuse in a sample of three.

Findings include:

The facility's Abuse Prevention Policy, revised 8/20/2018, documents physical abuse may include such acts of violence as: striking (with or without an object), hitting, pushing, shoving, shaking, jerking, slapping, kicking, pinching, and burning. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or family, or within their hearing distance, regardless of their age, ability to comprehend, or disability. It includes, but not limited to, staff yelling, swearing, threats of harm, gesturing, or using derogatory names, obscenities, and/or threatening language. This form also documents that, as part of the resident social history evaluation and Minimum Data Set (MDS) assessments, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment, or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify problems, goals, and approaches which would reduce the chances of abuse, neglect, or mistreatment for these residents. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation. If mistreatment has occurred, the resident's representative and the Department of Public Health shall be informed as soon as possible, within 24 hours.

On 8/15/25, both R1 and R2 were observed moving throughout the facility independently.

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R2's Progress Notes, dated 7/16/25, document a conflict between R2 and R1. It was reported that R1 and R2 were yelling and swearing at each other over bingo chips. R1 reached to grab bingo chips, and R2 slapped his hand. The two proceeded to threaten each other. R1's Progress Notes, dated 7/17/25, documents R2 had a verbal altercation with R1 at the dinner table.

R1's Progress Notes, dated 7/16/25, documents a conflict between R1 and R2. It was reported the two of them began yelling and swearing at each other over bingo chips. R1 reached over for bingo chips, R2 slapped R1's hand. The two proceeded to threaten each other. R1 reiterated that R2 slapped his hand "hard." R1's Progress Notes, dated 7/17/25, documents R1 was involved in a verbal altercation with another resident (R2) at the dinner table.

On 8/15/25 at 10:30am, R2 stated he was in the activity room getting ready for bingo when R2 rolled up next to him and started to grab the bingo chips in the center of the table. R2 stated he told R1 the chips were his (R2). R2 stated R1 reached over again to grab the bingo chips, so he slapped his hand away. R2 verified he did make contact with R1.

On 8/15/25 at 11:30am, R1 stated he went to bingo and sat next to R2. R1 stated he started to grab some bingo chips that were sitting in the middle of the table. R1 stated R2 began to yell and curse at him, telling him he can not have the chips. R1 stated R2 slapped the chips out of his hand and punched the back of his hand. R1 stated R2 was taken away for an appointment. R1 stated the next day, they both were sitting at the dining room table waiting for dinner, when R2 began to make smart comments towards R1. R1

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stated R2 threatened to "kill me." R1 verified R2 was removed from the table, then moved to the other side of the facility. R1 also stated R2 had since come to this unit, trying to instigate altercations with him.

O 8/15/25 at 11:45am, V3, Activity Therapist, stated she heard a commotion between R1 and R2 during bingo. V3 stated R1 took some of the bingo chips and R2 was making threats towards R1. V3 stated she was attempting to separate the two, when R2 hit R1 on the back of his hand with a closed fist.

On 8/15/25 at 2:00pm, V2, Director of Nursing, stated R2 was moved to the other side of the building because of the altercations with R1. V2 stated R2 will get fixated on a resident and act out verbally and make threats. V2 verified neither R1 nor R2's care plans were updated with abuse goals and interventions. V2 verified the first incident between R1 and R2 was reported, but the second incident was not.

(B)