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	IL6015481	A. BUILDING: _____ B. WING _____	09/30/2025

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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 Findings 1 of 2 340.1300 a) 340.1335 c)6) 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 340.1335 Infection Control c) Each facility shall adhere to the following guidelines and toolkits of the Center for Infectious Diseases, Centers for Disease Control and Prevention, U.S. Public Health Service, Department of Health and Human Services, and Agency for Healthcare Research and Quality (see Section 340.1010): 6) 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. This REQUIREMENT was not met as evidence by:	S9999		

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Based on observation, interview, and record review, the facility failed to ensure staff wore required PPE (personal protective equipment) while caring for residents positive with COVID-19. This applies to 3 of 22 residents (R16, R17 & R18) reviewed for infection control in the sample of 22.

The findings include:

1. On 9/29/25 at 10:25 AM, R17's door frame had a sign that showed, "special droplet precautions." V3, Social Worker, went into R17's room. She was only wearing an N95 face mask. She did not wear a gown, gloves, or face shield.

On 9/30/25 at 8:35 AM, R16's door frame had a sign that showed, "special droplet precautions." V4, Veterans Nurse Assistant-Certified (VRNC), was picking up R16's breakfast tray in his room. She was not wearing an N95 face mask.

On 9/30/25 at 10:30 AM, V27, Infection Control Nurse, stated, "Staff should be wearing a gown, gloves, N95 face mask and protective eyewear (goggles or face shield) when entering any COVID positive resident room."

R16's current physician order sheet provided by the facility on 9/30/25 shows, "Droplet + Contact + N95 due to COVID-19 for 10 days have passed since the onset of symptoms or positive test (if asymptomatic) and 24 hours have passed since the last fever without the use of fever reducing medications and symptoms (such as cough and shortness of breath)have improved with a start date of 9/23/25."

R17's progress notes dated 9/25/25 shows, "POA (power of attorney) updated on COVID test

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S9999	Continued From page 2 positive and plan of care ...." 2. On 9/30/25 at 8:52 AM, V11 (Registered Nurse/RN) prepared R18's morning medication, and said R18 is on isolation for COVID. A sign outside of R18's room shows he is on special/droplet contact precautions including instructions for staff to wear a gown, mask, gloves, and face shield. V11 (RN) donned a gown, gloves, and N95 mask. V11 did not put on eye protection, entered R18's room, and administered his medications. On 9/30/25 at 9:11 AM, V15 (RN) said, "Staff should wear a gown, gloves, N95 mask and eye protection when entering a COVID positive room." R18's Physician Order Sheets, dated September 2025, shows orders including maintain COVID isolation precautions every shift for 10 days. The facility's COVID-19 response strategy, dated 7/25/24, shows, "Policy: It is the policy of the Illinois Department of Veterans' Affairs to mitigate COVID-19 transmission through a multifaceted response strategy. Each Veterans' Home shall isolate residents with known or suspected COVID-19. The Home, in collaboration with the local health department, will conduct contact tracing and make appropriate notifications. Procedure: IV. Transmission-based precautions: Staff shall observe transmission-based precautions and use personal protective equipment (PPE) as follows. A. For residents in isolation or quarantine: 1. When in a resident's room, the staff member shall adhere to Standard Precautions and shall wear a NIOSH-approved N95 or higher level respirator, gown, gloves and eye protection ...."	S9999		

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S9999	Continued From page 3 (B) 2 of 2 340.1300 a) 340.1440 b) 340.1440 f) 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 b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (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) These requirements were not met as evidenced	S9999		

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by:

Based on interview and record review, the facility failed to ensure residents were free of verbal abuse by R8 for 3 of 3 residents (R9, 911, and R10) reviewed for abuse in the sample of 22.

The findings include:

1. R8's facility assessment, dated 8/26/25, show R8's BIMS (Brief Interview for Mental Status) score was 14-showing no cognitive impairment, with diagnoses of malignant neoplasm of prostate, generalized anxiety disorder, mood disorder, delusional disorder, and traumatic brain injury.

R9's facility assessment, dated 9/16/25, show R9's BIMS score was 15- showing R9 has no cognitive impairment, with diagnoses that include, paraplegia, neuropathy, and anxiety disorder.

On 9/29/25 at 12:35 PM, R9 said it has been more than once that he was verbally abused by R8. R9 said he was having a visit with his wife, they were in the courtyard when suddenly, this resident (R8) started screaming at them "f--- you! f--- you! then R8 "attempted to go towards us, continued to verbally abuse us, and harassed us. I felt so threatened, my wife (V9) was in tears, we both did not feel safe. My wife had to get the Nurse." At another time, R9 said R8 disrupted one of his family visits. R9 said they had to get security to take R8 away from R9. R9 stated "that was so unfair. No one should be treated that way." R9 said R8 was also known to be verbally abusive to other residents.

On 9/30/25 at 9AM, V9 (R9'wife) said she had written down the times that R8 verbally abused

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R9 and family. V9 said on 8/5/25 during one of her visits with R9, they were both in the courtyard when "(R8) came at us, he was so enraged and screaming, 'f--- you, f--- you' repeatedly at us. I felt we were being attacked; I was so scared! I went and got the Nurse." V9 said they do not deserve being abused. V9 said at another family visit last Labor Day weekend with R9 and other family members, R8 once again came at them, R8 was "again yelling f--- you, f--- you, called out my husband's first name (R9) repeatedly! this was plain harassment and abuse. Security came to calm (R8) down. No one should put up with this verbal abuse."

On 9/30/25 at 8:30 AM, V5 (RN) said that day (8/5/25), she saw R9's wife (V9) coming from the Northwest courtyard, V9 was so distraught, and tearful. V9 said they cannot take the cursing and verbal abuse of R8 towards them. V5 said she removed R8 from the courtyard and reported the incident to her supervisor. (V8)

An incident report, dated 8/5/25, under occurrence documents, "verbal altercation with another resident staff intervened he (R8) yelled profanities at (R9) and (R9's) wife (V9). The same document showed: "Supervisor notified was (V8, Public Service Administrator-PSA/Nurse Manager)."

On 9/30/25 at 11:44 AM, V8 (PSA) said she was informed of the incident on 8/5/25. V8 said there was a clinical meeting after 8/5/25, V2 (PSA DON) was there, V8 said she thought V1 (Administrator) was informed of the incident.

On 9/30/25 at 10:16 AM, the Facility Reported Incident (FRI) was requested regarding 8/5/25. V1 (Administrator) said the incident last 8/5/25

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was not reported to the State Agency because she was not informed at the time the incident happened. V1 said all abuse allegations should be reported to the Abuse Coordinator (V1) All the PSA-Nurse Managers were to report all allegations of Abuse to V1.

A facility reported incident (FRI), dated 9/7/25 as final documents: on 8/31/25, "(R9) was visiting with family in (room) when (R8) entered and noticed (R9), (R8) moved towards (R9) in his wheelchair and began yelling and screaming at (R9). (V9, R9's wife) immediately left the room to get the security guard. (R8) was removed from the situation and escorted him out of the hall."

A witness statement, dated 8/31/25 timed at 2:20 PM by V15 (RN), documents: "wife of (R9) approached nurses' station in tears wanting to report that (R8) came right at (R9) during a family visit ... not the first time this has happened. Went to check situation, ensure safety of both residents(R8) was still screaming "f--- him!' (R8) was resistive but able to get him back to his unit."

On 9/30/25 at 10:16 PM, V1 said both times R8 threatening and harassing R9 were verbal abuse.

2. On 9/29/25 at 2:30 PM, R11, who was alert and oriented, with diagnoses of TIAs (transient ischemic attacks), dementia, and depression said he was quietly sitting in his wheelchair in the hallway. "This guy (R8) suddenly said "FU" to me repeatedly, and then he tried to hit me, but was only able to reach the back of my wheelchair. I guess I will need to protect myself next time. He cannot do that to me again."

A facility Reported incident (FRI), dated 9/7/25 (initial report date 9/3/25), shows, R8 was outside

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when rain started to come down heavily. R8 was escorted inside by V16 (Certified Nursing Assistant-CNA); R11 was sitting in the middle of the hallway. R8 yelled at R11 to get out of the way.

An incident report, dated 9/3/25 by V16 (CNA), documents, "(R8) was outside the courtyard, it began to rain so I walked with him to go inside. (R11) was sitting in his wheelchair the middle of the hallway, (R8) started screaming at (R11), (R8) attempted to grab (R11's) wheelchair to get closer to (R11). (R11) was then assisted to get out of the way."

On 9/30/25 at 10:20 PM, V2 (PSA DON) said when a resident makes unwanted verbal threats that makes the other resident unsafe, that is verbal abuse.

3. On 9/29/25 at 1:10 PM, R10 was in his room sitting in his wheelchair, with his grabber on his bedside table. R10 said R8 is a "rough character." On 9/20/25, he was in his room when "(R8) was walking in the hallways yelling "F*** You" repeatedly and cursing at me. (R8) then came to my room, threatening me and he was going to attack me." R10 said he had his grabber and pointed it at him, and R8 lost his balance and fell. R10 said he did not think he would have to defend himself here, and R8 was recently moved to this unit because he did the same thing to another resident.

On 9/30/25 at 11:24 AM, V1 (SPSA) confirmed there was a verbal altercation regarding R8 with R10. Any allegations of abuse are investigated.

On 9/30/25 at 12:14 PM, V13 (Support Service Coordinator) said on 9/20/25, he saw R8 yelling

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at R10. R8 was yelling "F*** You" and approached R10 in his room. When he got to R10's room, R10 had his grabber directed at R8. R8 was standing across from R10 lost his balance and fell. When R8 was on the floor, he was still yelling at R10. V13 said if he had not intervened there would have been a physical altercation.

The facility's Abuse Final Investigation, dated 9/26/25, shows on 9/20/25 at approximately 7:50 AM, (R8) walked down the hall from his room to the next doorway ...(R8) stood at (R10's) doorway and began yelling at (R10). (R10) picked up his grabber, pointed it at (R8) and told him to get out of his room.

R10's Nursing Note, dated 9/10/25, documents, "(R8) was in another resident's room and witnessed staff to be attacking the other resident (R10). (R8) yelling, angry, agitated, and refusing to be assessed ...(R8) was separated and placed in the dining room as soon as (R10) was seen in the hallway, (R8) began yelling angrily and attempting to get to (R10) ...911 called to send police .... (R10) is a risk for his own safety and others."

The facilities Abuse Prevention Policy, revised 2018, states, "All residents will remain free from abuse, neglect, punishment, misappropriation of property, and involuntary seclusion ...IDVA (Illinois Department of Veterans Affair) has a Zero Tolerance for any form of resident abuse ...Verbal Abuse this is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. It includes, but is not limited to, staff yelling, swearing, threats of harm, gesturing or using

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S9999	Continued From page 9 derogatory names, obscenities and/or threatening language." (B)	S9999		