STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015473	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT QUINCY	1707 NORTH 12TH STREET QUINCY, IL 62301

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S 000	Initial Comments Complaint Investigation #2420037/IL168318	S 000		
S9999	Final Observations Statement of Licensure Violations: 340.1440b) 340.1440d) 340.1440f) 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) 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) These requirements are not met as evidence by: Based on observation, interview, and record review the facility failed to protect a resident from	S9999		

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physical abuse, identify physical abuse, immediately report physical abuse allegations to the administrator, and report physical abuse to the State Agency for five of five abuse incidents reviewed. This has the potential to affect 27 residents (R1-R27) residing on the dementia unit.

Findings include:

The facility's Abuse Prevention, Reporting, and Investigation policy, dated 2/23, documents, "Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Physical abuse-The use of physical force that can result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as striking (with or without an object), hitting, beating, pushing, shoving, shaking, jerking, slapping, kicking, pinching, and burning. During orientation of all new employees and on a periodic basis thereafter the Facility Abuse, Prevention, Reporting, and Investigation policy will be presented and reviewed. The facility Administrator or his designee will notify the State Agency."

1. On 1/8/24 at 11:00 a.m., R2 was pacing aimlessly back and forth throughout the facility's dementia unit.

On 1/8/24 at 11:55 a.m., R2 was in the facility day room with several residents present agitated and lifting chairs above his head.

R2's Abuse Prevention Plan & Susceptibility to Abuse/Safety Checklist assessment, dated 12/15/23, documents that R2 is assaultive, combative, or abusive to others as well as verbally threatening to others.

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A facility incident report dated 1/7/24 at 6:15 p.m., documents, "(R6) was sitting in the dayroom in his wheelchair for the evening activity. (R2) was wandering in and out of the dayroom frantic and naked. Due to the amount of wheelchair members, I (V15 Activities) redirected (R2) to a chair for his own safety and (V13 Registered Nurse) ran to get him some clothes. We suspected he was cold. After dressing (R2) we tried to direct him to the other half of the dayroom so he wouldn't trip over any wheelchairs. He went the opposite direction. Saw (R6's) foot, reached, down picked it up and said, 'oh that's mine.' I tried to prevent him, but he was quicker and (V13) and I had to both get him to let (R6's) foot go."

A facility incident report dated 1/8/24 at 9:44 a.m., documents, I (V14 Restorative CNA-Certified Nursing Assistant) was walking by and (R2) had (R5) by the legs. (R2) had pulled (R5's) legs to the side of the bed. I stopped him from pulling on him anymore. I covered (R5) back up in bed. (R2) then uncovered him again and tried to take off (R5's) boots. I asked (R2) not to do that please. (R2) yelled at me and said the F word. Then (R2) started rummaging in (R5's) room. (R2) picked up a heavy black chair and slammed the black chair next to (R5's) bed.

A facility incident report dated 1/8/24 at 9:46 a.m., documents, "I (V7 Registered Nurse) heard (R2) yelling and I approached (R3's) room and observed (R2) pulling on (R3's) legs while (R3) was laying in his bed. Staff intervened and (R2) left room."

On 1/8/24 at 10:45 a.m. V7 (Registered Nurse) stated, "Around 9:40-9:50 a.m. (1/8/24), (V14) saw (R2) in (R5's) room pulling on the other

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residents' legs. She alerted this to me. Then I heard (R2) yelling, he went into another resident's room (R3) and when I got in there he was pulling on his leg. Yesterday, he was pulling on (R6's) legs. He was agitated walking around the day room. (V13 Registered Nurse) and a CNA and I stood up when I heard the commotion and saw (R2) with his hands on (R6's) feet. Yesterday (1/7/24) we notified the nurse practitioner and (R2's) Power of Attorney and (R6's) Power of Attorney. I'm not sure if there was an incident report filled out. I've got the incident reports started for today's incidents. For the incidents today, I've notified the Power of Attorneys and the nurse practitioner. I didn't notify the Administrator. I'm new here so I'm not really sure if this would be considered abuse or just an incident. I would have to ask. I'm not really sure who our abuse coordinator is I would have to ask the other nurse or the supervisor. If I witness abuse or abuse was reported to me, I would contact my unit coordinator and then get the number for whoever is our abuse coordinator."

The facility has no documentation of the facility administrator, nor the State Agency being notified of R2's incidents on 1/7/24 and 1/8/24.

2. R3's Abuse Prevention Plan & Susceptibility to Abuse/Safety Checklist assessment, dated 10/4/23, documents that R3 is assaultive, combative, or abusive to others as well as verbally threatening to others.

R3's Nurses notes, dated 8/21/23 at 11:35 a.m., document, "R4 propelling self in hallway and rolled up to R3 and yelled at him and started to hit him with an open hand. R3 yelled back and hit R4 back with closed hand and members were separated by Activities staff that was in hallway.

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Staff report that members hit each other on the arms."

A facility incident report dated 8/21/23 at 11:15 a.m., documents, "I (V15 Activities) was walking (R8). (R3) was independently walking/wandering, (R4) was independently cruising/wandering. (R3) decided to turn around and (R4) started yelling and smacked (R3's) arm, (R3) then started to hit back and I said please don't hit while reaching in to block the hitting." The incident report has no documentation of the facility administrator, nor the State Agency being notified of the incident.

On 1/8/24 at 10:45 a.m., V15 stated that if she witnessed abuse, she would notify the charge nurse, and that she did not notify the administrator when she witnessed R3 and R4's incident on 8/21/23.

R3's Nurses' notes, dated 12/6/23 at 11:10 a.m., document, "R10 was walking in the hallway outside of room 116 when R3 came out of room and said, 'don't come in here' and pushed R10 backwards. This nurse and R10's wife were in the hallway talking and witnessed interaction. R10's wife called out to R10 to come back over to her and when he turned towards his wife R3 pushed R10 backwards again. R10 turned back to face R3 and pushed him backwards. This nurse (V13 Registered Nurse) stepped between members and separated them sending R10 away to walk with his wife. This nurse asked R3 what happened, and he stated, 'He was in my bed.' This nurse explained to R3 that R10 was in the hallway, and he can't push people for being in the hallway. R3 yelled at this nurse and this nurse expressed that he is welcome to close his door if he wants to, but he can't put his hands on others. R3 said 'Well he hit me.' This nurse explained

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that I did see him push him back."

On 1/8/23 at 2:00 p.m., V13 stated, "On 12/6/23, (R3) and (R10) both shoved each other. I was right there when it all happened. With our residents having dementia we don't consider these altercations abuse because they don't really know what's going on. On 8/21/23, (R3) and (R4) physically hit each other, but again I don't consider that abuse since they have dementia. If an altercation happens between two residents, I notify both responsible parties and the physicians. Then, I notify whoever the nurse supervisor is on duty. At no point do I notify (V2) or the administrator that is not my job to do that. I believe the nurse supervisor takes care of that."

The facility has no documentation of an abuse investigation for the event that occurred between R3 and R10 on 12/6/23. Also, there is no documentation of the facility administrator, nor the State Agency being notified of R3's incident on 8/21/21 or 12/6/23.

On 1/8/23 at 1:15 p.m., V2 (Director of Nursing) stated that if it's an altercation between two residents who have dementia, it's not reported as abuse because we don't consider it abuse. The nurse filling out the incident report should notify the supervisor of the incident. The nurse doesn't notify the administrator. The administrator would be notified by (V2), who is notified by the nursing supervisor. We would only notify the administrator if we thought there was abuse, and we didn't consider (R2) or (R3's) incidents abuse since they both have Dementia. (R2) ambulates independently around the whole dementia unit.

On 1/10/24 at 1:20 p.m. V2 confirmed there was no investigation for R3 and R10's incident on

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S9999	Continued From page 6 12/6/23. V2 also confirmed that the administrator nor the State Agency were notified of R2's incidents on 1/7 & 1/8/24 or R3's incidents on 8/21 & 12/6/23. The facility's Resident Matrix Form 802, documents that 27 residents (R1-R27) reside on the facility's dementia unit. (C)	S9999		