| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ` ′   |   |                     | (X3) DATE SURVEY<br>COMPLETED  |         |                          |
|---|---|---|---|---------------------|--|---------|--------------------------|
|   |   | A. BUILDING:  |   |                     |  |         |                          |
|   |   | IL601548  | 1   | B. WING             |  |         | C<br><b>)7/2024</b>      |
| NAME OF F   | PROVIDER OR SUPPLIER  |   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  | ·       |                          |
| II I INOIS  | VETERANS HOME A   | TIAGALLE  | 1015 O'C  | ONNOR AVE           | NUE  |         |                          |
| ILLINOIS  | VETERANS HOWE A   | ILASALLE  | LA SALLE  | E, IL 61301         |  |         |                          |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STA<br>(EACH DEFICIENCY<br>REGULATORY OR L  |   | DED BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETE<br>DATE |
| S 000   | Initial Comments  |   |   | S 000               |  |         |                          |
|   | Complaint Investiga<br>2420557/IL168970<br>2420217/IL168543<br>2420301/IL168647   | - 340.1305 a) l   | o), 340.1710  |                     |  |         |                          |
| S9999   | Final Observations  |   |   | S9999               |  |         |                          |
|   | 1 of 2  |   |   |                     |  |         |                          |
|   | Statement of Licens   | sure Violations:  |   |                     |  |         |                          |
|   | 340.1300 a)<br>340.1305 a)<br>340.1305 b)   |   |   |                     |  |         |                          |
|   | Section 340.1300 If a) The facility procedures governifacility. The written be formulated with administrator. The Act and this Part. If followed in operating reviewed at least arphysician or the meevidenced by a date.                           | shall have writting all services policies and policies and policies shall controlled by the facility are policies and policies shall of the written policies and ally by the facility are dical advisory. | en policies and provided by the rocedures shall it of the omply with the cies shall be ad shall be acility's advising |                     |  |         |                          |
|   | Section 340.1305 I<br>History Record Info<br>a) A facility sha<br>admission of a resid<br>background check<br>Conviction Informat<br>persons 18 or older<br>facility, unless a bac<br>by a hospital pursua<br>Act. Background coresident's name, da | rmation all, within 24 ho dent, request a pursuant to the ion Act [210 IL seeking admis ckground chec ant to the Hosp necks shall be  | ours after criminal history Uniform CS 2635] for all ssion to the k was initiated ital Licensing based on the         |                     |  |         |                          |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:   | E CONSTRUCTION      |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|--|--|---------------------|---|-------------------------------|--------------------------|
|  |  | IL6015481  | B. WING             |   |                               | C<br><b>07/2024</b>      |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   | ·                             |                          |
| ILLINOIS   | S VETERANS HOME A  | TIASALIF   | ONNOR AVE           | NUE   |                               |                          |
|  | T  | LA SALLI   | E, IL 61301         |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETE<br>DATE |
| S9999  | Continued From pa  | ge 1   | S9999               |   |                               |                          |
|  | identifiers as require Police. (Section 2-2 b) The facility name on the Illinois website at www.isp Department of Correpage at www.idoc.s individual is listed at These REQUIREM evidenced by:  Based on interview failed to initiate the resident back grour Record Information for nine (R8-R12, a reviewed for Crimin       | ed by the Department of State 201.5(b) of the Act) shall check for the individual's Sex Offender Registration state.il.us and the Illinois ections sex registrant search tate.il.us to determine if the s a registered sex offender.  ENTS are not met as  and record review, the facility required screening for and checks for Criminal History within 24 hours of admission and R14-R17) of ten residents al Background checks in a has the potential to affect all                           |                     |   |                               |                          |
|  | Findings include:  |  |                     |   |                               |                          |
|  | revised 1/5/17, doc<br>Process: B. Crimina<br>Offender Registration<br>offender registration<br>Nursing Home Care<br>and Illinois Adminis<br>340.1315. 2. All app<br>criminal history and<br>check conducted previewed by the AR<br>Committee). 3. A se<br>offender registration<br>Adjutant or designe<br>pursuant to Nursing | sion of Residents policy, uments, "6. Application al history check and Sex on check: 1. The Adjutant or uct criminal history and sex of checks as required by the e Act (210 ILCS 45/2-201.5) trative Code Title 77, Section olicants will have an initial sex offender registration rior to the application viewing C (Application Review econd criminal history and sex of check will be initiated by the e, on the day of admission, I Home Care Act (210 ILCS nois Administrative Code Title |                     |   |                               |                          |

Illinois Department of Public Health

| AND DIAN OF CODDECTION IDENTIFICATION NUMBER |   | 1 ' '  | E CONSTRUCTION      |  | (X3) DATE SURVEY<br>COMPLETED  |                          |
|--|---|--|---------------------|--|--------------------------------|--------------------------|
|  |   | IL6015481  | B. WING             |  |                                | C<br><b>07/2024</b>      |
| NAME OF                                      | PROVIDER OR SUPPLIER  |  | I<br>INDESS CITY S  | STATE, ZIP CODE  | UZI                            | J172024                  |
|  |   | 1015 O'C   | ONNOR AVE           |  |                                |                          |
| ILLINOIS                                     | S VETERANS HOME A   | ATIASALIF  | E, IL 61301         |  |                                |                          |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| S9999  | Continued From pa   | nge 2  | S9999               |  |                                |                          |
|  | 77, Section 340.13  | 15."   |                     |  |                                |                          |
|  | Resident and Facili<br>Term and Terminat<br>on the day it is sign<br>terminated under the<br>residents will be sulply the Illinois State<br>admission. This confirmediately in acconfirmediately | documents R8 admitted to the   |                     |  |                                |                          |
|  | facility on 1/3/24. R8's background screenings were completed on 11/9/23.  R9's clinical record documents R9 admitted to the facility on 1/17/24. R9's background screenings  |  |                     |  |                                |                          |
|  | the facility on 01/24   | d documents R10 admitted to<br>4/24. R10's background<br>ompleted on 12/5/23.        |                     |  |                                |                          |
|  | the facility on 12/19   | d documents R11 admitted to<br>0/23. R11's background<br>ompleted on 10/27/23.       |                     |  |                                |                          |
|  | the facility on 12/12   | d documents R12 admitted to<br>2/23. R12's background<br>ompleted on 10/27/23.       |                     |  |                                |                          |
|  | the facility on 11/7/2  | d documents R14 admitted to 23. R14's background ompleted on 10/11/23.               |                     |  |                                |                          |
|  | R15's clinical recor  | d documents R15 admitted to  |                     |  |                                |                          |

Illinois Department of Public Health

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING:  |                     |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|--|---------------------|---|-------------------------------|--------------------------|
|  |   | IL6015481  | B. WING             |   | C<br><b>02/07/2024</b>        |                          |
| NAME OF  | PROVIDER OR SUPPLIER  |  | DRESS, CITY, S      | STATE, ZIP CODE   | 1 02/0                        |                          |
| ILLINOIS   | VETERANS HOME A   | TIASALIF   | ONNOR AVE           | NUE   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| S9999  | Continued From page 3   |  | S9999               |   |                               |                          |
|  |   | /23. R15's background<br>ompleted on 10/27/23.   |                     |   |                               |                          |
|  |   | d documents R16 admitted to<br>23. R16's background<br>empleted on 8/9/23.   |                     |   |                               |                          |
|  | R17's clinical record documents R17 admitted to the facility on 11/14/23. R17's background screenings were completed on 9/22/23.  |  |                     |   |                               |                          |
|  | The facility's Admissions Record dated 2/7/24, provided by V1 Administrator, confirmed the above residents and admission dates.  On 2/7/24, at 11:35am ,V18, Reimbursement Officer, stated the following: V18 runs the background checks for new admissions when the application is complete and we are getting ready to review them with the medical team. The dates vary a lot and depends on how long our wait list is. I do not run them again 24 hours before they arrive. |  |                     |   |                               |                          |
|  |   |  |                     |   |                               |                          |
|  | Administrator, state states to do the bac resident's application the day of admis hour background cl  | n 12:20pm - 1:55pm, V1,<br>ed the following: Our policy<br>ekground checks when the<br>on is submitted, and then again<br>esion. V1 confirmed the 24<br>hecks have not been<br>eir previous Adjutant left in |                     |   |                               |                          |
|  | (C)   |  |                     |   |                               |                          |
|  | 2 of 2  |  |                     |   |                               |                          |
|  | 340.1710  |  |                     |   |                               |                          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPL<br>A. BUILDING:  | E CONSTRUCTION  |                     | (X3) DATE SURVEY<br>COMPLETED  |                              |                          |
|--|--|---|---|---------------------|--|------------------------------|--------------------------|
|  |  | IL6015481   |   | B. WING             |  |                              | C<br><b>07/2024</b>      |
| ILLINOIS VETERANS HOME AT LASALLE 1015 O'CC                                  |  |   | DRESS, CITY, S<br>DNNOR AVE<br>E, IL 61301  | STATE, ZIP CODE     |  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIE<br>MUST BE PRECEDE<br>SC IDENTIFYING INFO   | D BY FULL   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| S9999  | Continued From particles of Section 340.1710 of the staff member Services is not a So have an effective at Worker to provide of the Services of the Section 340.1710 of the Section Se | Social Services designated to procial Worker, the rrangement with social service con NT is not met as and record reviequalified Social Sof the residents. Il 87 residents residents residents and Worker II Positional Worker by the resional Regulationare and Medicaic etailed Explanationare and Medicaic etailed Explanationare and Medicaic etailed Explanationare and Illinois." In certificate of lice the guideline State of Illinois." In certificate of lice am not licensed as hired here in 2 ired. (V19) previous here and licensed is August. | e facility shall a Social nsultation.  evidenced by:  ew, the facility ervice Worker This has the siding in the siding in the siding in the on ts, "Requires Illinois tion."  CMS I Services) on, dated lly licensed as and This same file censure in the following: I ervice as a Social on, I was ous Social sed. (V19) | S9999               |  |                              |                          |

Illinois Department of Public Health

STATE FORM DEDG11 If continuation sheet 5 of 6

| NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   |           | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIED IDENTIFICATION NUM  |                                       | ' '    | E CONSTRUCTION                                | (X3) DATE<br>COMF                 | SURVEY<br>PLETED |
|--|-----------|--|--|---------------------------------------|--------|---|-----------------------------------|------------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  ILLINOIS VETERANS HOME AT LASALLE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  S9999 Continued From page 5  Resource) Specialist, confirmed V4, SSW, is not licensed. V6 said this has come up before. We thought it was okay back when (V4) was hired in 2009. V6 confirmed they had a licensed Social Services worker here at that time.  On 2/6/24, at 3:32pm, V1, Administrator, confirmed V4 is not a licensed Social Service Worker, and they have not used any services by a licensed Social Service Consultation. |           |  | II 6045494   |                                       |        |   |                                   |                  |
| ILLINOIS VETERANS HOME AT LASALLE  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 5  Resource) Specialist, confirmed V4, SSW, is not licensed. V6 said this has come up before. We thought it was okay back when (V4) was hired in 2009. V6 confirmed they had a licensed Social Services worker here at that time.  On 2/6/24, at 3:32pm, V1, Administrator, confirmed V4 is not a licensed Social Service Worker, and they have not used any services by a licensed Social Service Consultation.   |           |  | 120013401  |                                       |        |   | 02/0                              | 0112024          |
| ILLINOIS VETERANS HOME AT LASALLE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999 Continued From page 5  Resource) Specialist, confirmed V4, SSW, is not licensed. V6 said this has come up before. We thought it was okay back when (V4) was hired in 2009. V6 confirmed they had a licensed Social Services worker here at that time.  On 2/6/24, at 3:32pm, V1, Administrator, confirmed V4 is not a licensed Social Service Worker, and they have not used any services by a licensed Social Service Consultation.   | NAME OF I | PROVIDER OR SUPPLIER   |  |                                       |        |   |                                   |                  |
| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S9999  Continued From page 5  Resource) Specialist, confirmed V4, SSW, is not licensed. V6 said this has come up before. We thought it was okay back when (V4) was hired in 2009. V6 confirmed they had a licensed Social Services worker here at that time.  On 2/6/24, at 3:32pm, V1, Administrator, confirmed V4 is not a licensed Social Service Worker, and they have not used any services by a licensed Social Service Consultation.  | ILLINOIS  | S VETERANS HOME A  | T LASALLE  |                                       |        | NUE   |                                   |                  |
| Resource) Specialist, confirmed V4, SSW, is not licensed. V6 said this has come up before. We thought it was okay back when (V4) was hired in 2009. V6 confirmed they had a licensed Social Services worker here at that time.  On 2/6/24, at 3:32pm, V1, Administrator, confirmed V4 is not a licensed Social Service Worker, and they have not used any services by a licensed Social Service Worker to provide Social Service Consultation.   | PREFIX    | (EACH DEFICIENCY   | / MUST BE PRECEDED BY F  | FULL                                  | PREFIX | (EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1 | TION SHOULD BE<br>THE APPROPRIATE | COMPLETE         |
|  | S9999     | Resource) Specialis licensed. V6 said the thought it was okay 2009. V6 confirmed Services worker he On 2/6/24, at 3:32p confirmed V4 is not Worker, and they had licensed Social Service Constitution. | st, confirmed V4, SSV<br>nis has come up befor<br>back when (V4) was<br>d they had a licensed<br>re at that time.<br>m, V1, Administrator,<br>t a licensed Social Se<br>ave not used any ser-<br>ervice Worker to prov | re. We hired in Social rvice vices by | S9999  | DEFICIENC                                     | Υ)                                |                  |

Illinois Department of Public Health

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