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	IL6015481	A. BUILDING: _____ B. WING _____	C 06/17/2025

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S 000	Initial Comments Investigation of Facility Reported Incident of 5/12/25, IL192628-340.1505 a) b) Investigation of Facility Reported Incident of 5/17/25, IL193286-340.1300 a), 340.1440 a) b) e) Investigation of Facility Reported Incident of 6/01/25, IL194507-No deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 340.1300 a) 340.1440 a) 340.1440 b) 340.1440 e) 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) b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall	S9999		

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S9999	Continued From page 1	S9999		

immediately report the matter to the facility administrator. (Section 3-610 of the Act)
e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator 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. (Section 3-611 of the Act)

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to protect a resident from physical abuse by an employee, failed to report the incident immediately to the facility Abuse Coordinator, and failed to ensure an employee suspected of abuse was immediately suspended, for one of three residents (R1), reviewed for abuse, in a sample of 3.

The facility policy, Abuse Prevention Program, dated (revised) 8/20/2018, directs staff, "It is the policy of the (facility) in the operation of its state veteran's homes that all residents will remain free from abuse, neglect, punishment, misappropriation of property and involuntary seclusion. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other that by accidental means in a facility. Physical abuse: The willful use of physical force, that can result in bodily injury, physical pain or impairment and that requires (whether given) medical attention. Employees are required to immediately report any incident, allegation or suspicion of potential abuse, neglect or misappropriation of property they observe, hear

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S9999	Continued From page 2	S9999		

about, or suspect to the administrator, or an immediate supervisor who must then immediately report it to the administrator. Protection of Residents: Staff of this facility who have been accused of abuse, neglect or mistreatment will be removed from resident contact immediately until the results of the investigation have been reviewed by the administrator or designee. Staff accused of possible abuse, neglect or misappropriation of property shall not complete the shift as a direct care provider to the residents."

The facility form, Initial Incident Report: Abuse Allegation, dated 5/17/25, documents, "Administration received call that 3 dime- sized bruises were noted to resident's right hand and that (V7/VNAC- Veterans Nursing Assistant Certified) that (V6/VNAC) was being rough with resident cares. (V6/VNAC) sent home on administrative leave and investigation started. Full assessment completed on (R1)."

The facility form, Incident Report, dated 5/17/25 and signed by V2/Director of Nurses, documents, "Description of Incident: V8/VNAC noted small dime size bruises to (R1)'s right hand at 4:00 A.M. on 5/17/25. Summary of Investigation: A thorough investigation into this incident has been completed. Information was obtained from staff witness statements, chart review, staff interviews and resident interviews. Conclusion: (facility) concludes that (R1) suffered mistreatment from (V6/VNAC) which resulted in bruising to the top of his right hand."

The facility Unusual Occurrence/Incident Form, dated 5/17/25 and signed by V9/Registered Nurse, documents, "Time of Occurrence: states occurred 5/16/25 at 7:30 P.M. Reported to this

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S9999	Continued From page 3	S9999		

nurse at 4:00 A.M., on 5/17/25. (V8/VNAC) reported to this nurse at 4:00 A.M., that (V7/VNAC) told her that (V6/VNAC) was being rough with (R1) during 7:30 P.M. cares and to not be surprised if (R1) has bruises on his hands. (V8/VNAC) states that she noted three small bruises on (R1)'s hand during rounds and then reported this information to this nurse. Immediately went to do a head to toe assessment on (R1). Three bright, purple, dime- sized bruises noted to (R1)'s hand and a deep purple bruise on (R1)'s lower left medial leg. (V7/VNAC) reports that (V6/VNAC) was 'mad that I asked her to help me (with R1) and that (R1) was swinging which pissed (V6/VNAC) off more than she already was so she (V6) grabbed (R1)'s hands and wrists and held him down in a really rough way."

The facility form, Witness Narrative Statement, dated 5/17/25 and signed by V8/VNAC, documents, "On midnight rounds me and another VNAC went to check on (R1). I noted small purple bruises to his hand. Earlier that night (5/16/25) at approximately 7:30 P.M., I was walking up C Hall (when) (V6/VNAC) came out of (R1)'s room clearly upset, mad, frantic, mumbling, 'a, I will gladly leave.' I proceeded to enter (R1)'s room and (V7/VNAC) stated that (V6) was being extremely rough with (R1) and he will probably have bruises on his hands."

The facility form, Witness Narrative Statement, dated 5/16/25 and signed by V7/VNAC, documents, "I came in early at 7:00 P.M. on East (Hall). Upon checking the residents, I could tell that (R1) needed to be changed. I asked (V6) to help me take (R1) to his room. Once in (R1)'s room, (V6) was yelling about having to do cares on (R1) and complaining about (R1) always hitting her and abusing her. When we were

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S9999	Continued From page 4	S9999		

cleaning (R1), he was swinging at (V6). (V6) held (R1) down in a rough manner by his hands and wrists. (R1)'s roommate was lying in bed and witnessed all of this. Additionally, when I asked (V6) for help, she didn't say anything. V6 stood up and threw the (electronic device) on the nurses' desk and walked to (R1)'s room. I told (V10/Registered Nurse) what happened."

The facility form, Interview Form, dated 5/20/25 documents, "Name of Person Being Interviewed: (V6/VNAC). (V7) asked if I'd help her and I said yeah. (R1) started swinging and slapping and we got (the) toileting sling on him and after we got him up with the lift and to bed. (R1) had BM (bowel movement) up to his knees and back. (We were) trying to clean (R1) up and rolled (R1) towards (V7). (R1) was trying to smack us the whole time. It's so frustrating because I know it's a disease and (R1) can't help it but we need to care for (R1), trying to clean up the best we can. (R1) reached his hand and smacked me. I asked (V7) to hold him better so I could help (R1). I reached around and was trying to hold (R1)'s hands. (V7) called my name like she thought I was trying to hurt (R1) and I said I'm just trying to hold his hands. We had a heck of a time getting (R1) cleaned up and that was it. I didn't mean to hurt (R1). All I was trying to do was hold his hands."

The facility form, Interview Form, dated 5/20/25, documents, "Name of Person Being Interviewed: (V10/Registered Nurse). I was on A Hall, and I had my med (medication) cart at the end of the hall and was charting. I overheard (V7 and V8) saying all she does is run around here throwing things. (V7) told (V8) that when they put (R1) to bed that he was hitting and she (V6) grabbed (R1's) wrists. She said (R1) will probably have

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S9999	Continued From page 5	S9999		

bruises on his wrists because (V6) grabbed hard. Another resident's son asked about medications, and I told them to go tell (V4/Registered Nurse). I saw them talking outside of the room, so I assumed they were talking. (V6) was acting like she always does. She's very short fused. I have never seen her like this (before). She was stomping around saying I'm tired of doing all the work around here."

The facility form, Interview Form, dated 5/20/25, documents, "Name of Person Being Interviewed: (V4/Registered Nurse). No one reported anything to me. I didn't hear about it until the next day."

The facility form, (V6/VNAC) (Facility) Timecard for 5/11/25 to 5/17/25 documents hours worked for 5/16/25 as 1455 (2:55 P.M.) to 2300 (11:00 P.M.).

On 6/17/25 at 8:46 A.M., V7/VNAC stated she came to work early at 7:00 PM on 5/16/25. Stated she checked on all of her residents and noticed R1 needed to be changed. V7 stated V6/VNAC was the only aide available at the time. V7 stated V6 was charting on an electronic device, and when she asked V6 to assist her, V6 immediately became very angry, rolled her eyes, threw the electronic device on the nurses' station, stomped down the hall, grabbed the lift, and pushed it so forcefully it banged into the metal linen barrels in the hallway, causing a loud noise. V7 stated, "(V6) kept screaming over and over, 'I'm tired of doing cares for (R1). All he does is hit me and I don't have to take it and I'm not going to take it anymore.' At that point we had (R1) in bed and we had to roll him towards (V6). (V6/VNAC) grabbed (R1's) hands and wrists and held them down very tightly. All the time she is still screaming. At that point, I told her she needed to

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S9999	Continued From page 6	S9999		

stop, that she was hurting (R1), and she needed to leave the room. (V6) threw her hands in the air and stomped out of the room, still screaming about having to help (R1). Another aide (V8/VNAC) had heard all of the commotion and came into the room, and I told her what was going on, and told her I was sure that (R1) would have bruises by tomorrow. (V8) helped me get (R1) settled down for the night and I left the room. (V10/RN) was at that desk, and I immediately told her what had happened in (R1)'s room. I don't know if or when (V10) reported it to (V1/Administrator). I'm supposed to follow the chain of command and report any signs of abuse to a nurse, which I did. (V6/VNAC) worked the rest of her shift and left at 11:00 o'clock that night."

On 6/17/25 at 9:12 A.M., V2/Administrator stated she was on vacation at the time of the incident with R1, and V2/Director of Nurses investigated the allegation of abuse.

On 6/17/25 at 9:24 A.M., V2/Director of Nurses confirmed she was notified of an allegation of abuse on 5/17/25 at 12:50 A.M. from V9/Registered Nurse. V2/DON confirmed neither V7/VNAC nor V10/Registered Nurse called her to immediately report an allegation of abuse concerning R1 and V6 that occurred on 5/16/25 at 7:30 P.M. At this time, V2/DON also verified V6/VNAC was not immediately suspended on 5/16/25 and continued to have access to facility residents until she left the facility at 11:00 P.M. on 5/16/25. V2/DON then verified after an investigation, the facility founded the allegation of abuse against V6/VNAC) as having occurred.

(B)

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S9999	Continued From page 7 340.1505 a) 340.1505 b) Section 340.1505 Medical, Nursing and Restorative Services a) Comprehensive resident care plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident ' s care needs. The assessment shall be developed with the active participation of the resident and the resident ' s guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 develop a care plan to ensure resident safety for one (R2) resident who fell asleep while suntanning unsupervised and developed a third degree burn of three residents reviewed for supervision in a sample of three.	S9999		

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S9999	Continued From page 8	S9999		

Findings include:

The facility's Protecting your Skin: Sunburn Prevention for Older Adults, undated, documents "How to Prevent Sunburn", Use sunscreen, apply broad-spectrum SPF 30 or higher, even on cloudy days, reapply every 2 hours, wear protective clothing-Choose lightweight lone sleeves, pants, and wide-brimmed hats to shield your skin. Stay in the shade, avoid direct sun exposure between 10 AM and 4 PM, when UV rays are strongest."

R2's Progress Notes, dated 5/12/25, document R2 stated he had been out yesterday. His bilateral extremities display a sunburn. R2's legs are red and sensitive when drying his right leg. There was a 7cm (centimeter) by 5cm wound. The wound bed was pink, with no drainage noted.

R2's Progress Notes, dated 5/12/25 at 11:38am, document R2 stated he fell asleep while sitting outside in the sun over the weekend. R2's right leg had a 3rd degree sunburn present on the anterior lower leg, with a bullous lesion. The edges are oval-shaped, vertical oriented, flesh-toned, and gaping, measuring 7.5cm by 5.0cm by 0.2cm. The wound bed is moist and consists of approximately 80 percent thin and fragile, bright pink epithelial tissue and 20 percent light red granulation tissue, both of which are scattered throughout.

V2's current care plan does not address goals or interventions concerning R2 going outside sitting in the sun. R2's current Physician Order Sheet does not document orders for sunscreen while sitting outside in the sun.

On 6/16/25 at 9:30am, V11, Office Associate,

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S9999	Continued From page 9	S9999		

stated R2 is probably outside working on his tan. V11 stated R2 does not sign out, but he generally goes out to sit in the sun.

On 6/16/25 at 10:00am, R2 was sitting in the patio area in direct sunlight. R2 had a blanket covering his legs. R2 was startled at the sound of his name. R2 stated he fell asleep while sitting on the patio. R2 stated he goes out to the patio multiple times during the day. R2 stated he did fall asleep on the patio on Sunday. R2 stated he thinks he was asleep for a couple of hours.

On 6/16/25 at 1:00pm, R2 was observed going onto the patio. R2 stated he was going to work on his tan. R2 had on shorts, with his lower legs uncovered. R2 stated he did not remember anyone putting sunscreen on his legs.

On 6/17/25 at 9:25am, V2, Director of Nursing, verified R2 was free to roam about the facility independently. V2 stated R2 would usually tell someone at the nurse's station that he is going outside to sit on the patio. V2 stated the residents do not have to sign out when they are leaving the unit, but do have to sign out when leaving the property. V2's verified R2's care plan does not address R2 going outside to sit, unattended.

(B)