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 06/28/2025

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 Investigation of Facility Reported Incident of 5/7/25, IL193287- 340.1000, 340.1440 Investigation of Facility Reported Incident of 5/31/25, IL194529-No deficiency	S 000		
S9999	Final Observations Statement of Licensure Violations: 340.1000 340.1410f) Section 340.1000 Definitions Abuse - any physical or mental injury or sexual assault inflicted on a resident other than by accidental means in a facility. (Section 1-103 of the Act) Abuse means: Physical abuse refers to the infliction of injury on a resident that occurs other than by accidental means and that requires (whether or not actually given) medical attention. Section 340.1440 Abuse and Neglect 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	S9999		

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residents and employees of the facility. (Section 3-612 of the Act)

These requirements are not met as evidence by:

Based on interview and record review, the facility failed to prevent abuse for one resident (R1) of three residents reviewed for abuse in a sample of six. This failure resulted in R1 having a laceration to his lip that required three stitches.

Findings include:

The facility Abuse Prevention, Reporting and Investigation policy dated 9/6/06 documents "Purpose: To establish a resident sensitive and resident secure environment in which personnel are doing all possible to provide for the physical and emotional safety of residents of (the facility). Staff will follow proper prevention, reporting and investigation procedures as they become aware of incidents or are witness to incidents. Policy: All (facility) employees are committed to being proactive in providing for the well-being of all residents by the recognition and prevention of abuse and training and prevention measures. All alleged reports of patient abuse and neglect will be immediately reported and fully investigated. (Facility) will not tolerate abuse of our residents. Definitions: Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This also includes the deprivation by an individual, including a caretaker, (employee, volunteer, visitor, or family member) of goods or services that are necessary to attain and/or maintain physical, mental, and

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psychosocial well-being. This assumes that all instances of abuse of residents, even those in a coma, cause physical harm, or pain or mental anguish. 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. Signs and Symptoms of physical abuse may include but are not limited to 2. Bruises, black eyes, welts, lacerations, rope marks and cigarette burns. 6. Resident's reports of being hit, slapped, kicked, jerked, or mistreated."

R1's computerized Medical Record documents that R1 is a 79-year-old male that admitted to the facility on 4/24/25 with diagnoses which included Vascular Dementia, Mild, with Other Behavioral Disturbance, Unspecified Atrial Fibrillation, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side.

R1's MDS (Minimum Data Set) assessment dated 5/1/25 documents a BIMS (Brief Interview for Mental Status) of 3, indicating (severe cognitive impairment). R1 has upper and lower extremity impairment on one side, uses a wheelchair, requires substantial assistance for activities of daily living, bed mobility/transfers and is dependent for toileting. R1 has physical and verbal behaviors directed towards others that puts R1 and others at significant risk for physical injury.

R2's computerized Medical Record documents that R2 is a 79-year-old male that admitted to the facility on 4/13/25 with diagnoses which included Unspecified Dementia, Mild, with Agitation and

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Depression.

R2's MDS (Minimum Data Set) assessment dated 4/10/25 documents a BIMS of 4, indicating (severe cognitive impairment). R1 has no upper and lower extremity impairments, requires no devices for mobility, is independent for activities of daily living, toileting, bed mobility and transfers. R1 has verbal behaviors directed towards others. Puts others at significant risk for physical injury. Significantly disrupts care or living environment. R2 does wandering four to six days that significantly intrudes on the privacy or activities of others.

On 6/27/25 at 3:36 PM, V8/RN stated "I had just got to work, and I heard yelling from (R1's) room. (R2) was standing next to (R1's) bed with his fist raised. (R1's) lip was bleeding. I said (R2's) name and asked him to go for a walk with me. I yelled for (V9/Certified Nursing Assistant/CNA) to come help and stay with (R1). (R2) had a skin tear on his hand. Both residents were sent to the hospital for treatment of injuries and (R2) for a psych evaluation." V8 also stated "(R2) wanders around and (R1) is territorial so when (R2) went into (R1's) room and (R1) yelled at (R2) to get out (R2) hit (R1)."

On 6/27/25 at 3:47 PM, V9/CNA stated that he was in a resident's room and heard a nurse (V8) yell for help from R1's room. R2 was leaving R1's room as V9 got to the room. R1 had blood on his face. V9 was told by R1 that R2 hit R1 in the face. V9 stayed with R1 until R1 left for the hospital.

On 6/28/25 at 10:30 AM, R1 was sitting in his room in a wheelchair. R1 was asked if he has been abused. R1 stated that he was in bed when a male came in R1's room and had their fist in the

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air. "I spit on him. If I see him again, I'll jump on him. I'll put some hurt on him if he does it again. Pay backs are H***." R1 was asked if it hurt when he was hit. R1 stated "Sure it hurt." R1 did not remember getting stitches. R1 stated he would not get stitches because he did not want a scar. R1 had a lot of facial hair, and the injury was not visible.

The Final Incident Report on Abuse between R1 and R2 sent to (State agency) documents "On 5/7/25 at approximately 4:40 PM, staff heard (R1) yelling for help, nursing staff responded immediately to (R1's) room and found (R2) standing next to (R1's) bed with his fist up. RN (Registered Nurse) called for assistance, a (CNA) arrived in the room promptly and the nurse asked (R2) to take a walk with her to remove (R2) from the area, the nurse walked (R2) out into the hallway and noted (R2's) right hand was bleeding, she was able to clean (R2's) hand and assist (R2) to sit down in a chair. Nursing staff were also with (R1) and noted bleeding from (R1's) mouth, blood on the blankets, bedside table was knocked over and water was on the floor. (CNA) was able to apply gentle pressure to (R1's) upper lip, (CNA) stayed with (R1) until Security arrived at unit for transport via stretcher to the Emergency Department for evaluation, in the Emergency Department (R1) received 3 (three) sutures to his upper lip and the TDAP (Diphtheria, Tetanus, and Pertussis) immunization then returned to facility with orders for follow up with Nurse Practitioner for suture removal in 7 (seven) - 10 (ten) days. 911 was called, for (R2) with petition for Involuntary/Judicial Admission, (R2) was transferred via ambulance to the Emergency Department for evaluation and treatment. In the Emergency Department, an X-ray of (R2's) right hand was negative, and bloodwork was WNL

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(within normal limits), suggested order received to start Augmentin for abrasion to right third digit, (R2) return to facility."

Written Statement by V9/CNA dated 5/7/25 documents "I was walking out of a room when I heard the nurse calling me for help. So, I took off running to (R1's) room. When I got down there (R2) was walking out shaking his hand. (R1) was asking me to help him. (R1) was bleeding from the mouth and there was blood everywhere (R1's) lip was split open. (R1) said that guy (R2) was hitting (R1) in the mouth. The bedside table was turned over and things were thrown all over the room, so I stayed with (R1) until we sent (R1) out."

Written Statement by V10/RN dated 5/7/25 documents "This nurse was walking to restroom and heard (R1) yelling for help and yelling get that son of a b**** away from me. This nurse ran to (R1's) room, (R2) was standing next to (R1's) bed with fist (right hand) up. This nurse called (R2's) name and ask (R2) to take a walk with this nurse. (R1) was bleeding from left side of lip, blood was on blankets, (R1's) hand, running down (R1's) neck. This nurse yelled for (V9/CNA) to come help. (V9) ran to room and assisted with (R1). (R2) walked to chairs in hallway (R2) was bleeding from right knuckle, stating (R1) told (R2) to get out of (R1's) room. Bedside table was knocked over, water was on floor in room."

R1's Nursing Note written by V8/RN dated 5/7/25, documents "At 4:48 PM Staff member reported to this nurse that (R1) had been hit in the face and was bleeding. Found (R1) in his bed with blood running down (R1's) face. (R1) was yelling, "Keep that S*B out of my room!" "Staff reports that (R2) had gone into (R1's) room and hit (R1) in the

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face. (R1's) left side of mouth (lip) was bleeding and running down (R1's) neck. Attempted to calm (R1) down and clean (R1's) mouth, applied pressure to stop the bleeding. (R2) had been walked out of (R1's) room. Orders received to send (R1) out per security to ER (Emergency Room) to evaluate for lip laceration. (R1) left unit per security on stretcher at 5:15 PM."

R1's Hospital Transfer Note written by V8/RN dated 5/7/25 at 5:15 PM documents, "Reason for Transfer: (R1) was hit in the mouth by another resident (R2) and injured. Laceration left side of mouth-lip."

R1's Emergency Department Summary dated 5/7/25 documents "(R10) seen in the Emergency Department on 5/7/2025, with the chief complaint of lip pain."

R1's Nursing Note written by V8/RN dated 5/7/25 at 7:26 PM, documents "(R1) return to unit on stretcher per security. (R1) was upset and stated, "Wait till I get my hands on the guy." (R1) was referring to (R2) who had hit (R1). The left side of (R1's) mouth lip had three sutures. Attempted to gently remove some of the dried blood from around (R1's) mouth but (R1) refused."

R1's Social Service Note dated 5/8/25 at 8:36 AM, documents "Met with (R1) in his room after breakfast for a supportive visit regarding the incident with (R2). (R1) was calm and in no obvious distress. (R1) remembered the incident with some detail. (R1) talked about the incident in a matter-of-fact manner saying that there is nothing he can do about it and is leaving it in God's hands. He was not sure what caused the incident but said he (R2) came in there to "Hurt (R1)" and got the job done. (R1) said he would

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S9999	Continued From page 7 defend himself as best he could if it happens again by using his functional arm and leg but did not indicate any desire to seek (R2)." R1's Physician Progress Note dated 5/12/25 at 2:18 PM, documents "On 5/7/25 another resident entered (R1's) room and hit (R1) in the mouth. This caused a laceration to (R1's) lip, (R1) was sent to hospital and had sutures placed to left side of upper lip." (B)	S9999		