Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Illinois Veterans' Home – Anna

Location: 792 N. Main St, Anna, IL 62906

Onsite / Virtual: Onsite

Dates of Survey: 07/16/24 – 7/18/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 50

Census on First Day of Survey: 39

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 16, 2024, through July 18, 2024, at the Illinois Veterans' Home – Anna. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview, record review, and policy review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible for one (1) of three (3) sampled residents. Resident #1 was in possession of an un-prescribed bottle of Melatonin (an over the counter dietary supplement used most commonly for insomnia). The findings include: A review of an Incident Report, dated [DATE], revealed at 6:05 p.m., Resident #1 sustained an unwitnessed fall in their room. Continued review revealed that while the resident was being assisted off the floor and into a chair, staff observed a bottle of Melatonin on the floor, which was confiscated and disposed of at the nursing station. Review of the History and Physical, dated [DATE], revealed Resident #1 had been diagnosed with the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD), Benign Prostatic Hyperplasia, Chronic Pain, Depressive Disorder,

	Polyneuropathy, Diabetes Mellitus Type II (DM II), Multiple System Atrophy, and Hypertension (HTN). In an interview, on 7/16/24, at 2:45 p.m., with Licensed Nurse A, they stated they had been on duty on [DATE], when Resident #1 had fallen. Licensed Nurse A revealed staff had called them to Resident #1's room, and when they entered the room, the resident was on the floor and appeared to be confused, and was running a fever. Licensed Nurse A stated the resident had not been able to state what had happened. They revealed it had been at that time that they had observed a bottle of Melatonin on the floor. Licensed Nurse A continued to state they had taken the Melatonin to the [LOCATION] where it was discarded. Licensed Nurse A revealed they had not opened the bottle before they disposed of it; therefore, they were unable to state whether or not any of the dietary supplement had been taken. Licensed Nurse A stated residents should not have medications in their rooms. They stated no one in charge at the facility had spoken with them about any additional monitoring of Resident #1, or other residents, to ensure residents did not bring in, or did not take, any medications or supplements that had not been prescribed by their provider. Observation of Resident #1, on 7/17/24, at 8:35 a.m., revealed they were resting quietly in the bed. The resident was alert, awake, and talkative. Observation of Resident #1, on 7/17/24, at 9:40 a.m., revealed the resident was outdoors in a motorized wheelchair. The resident was alert, oriented, and talkative. A record review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility had admitted Resident #1 on [DATE]. Continued review revealed a Brief Interview for Mental Status score of 12, and the resident was interviewable. An interview, on 7/17/24, at 9:40 a.m., with Resident #1 revealed they had purchased a bottle of Melatonin at Wal-Mart sometime in [DATE]. They stated they had known better than to bring over the counter medications into the facility without a doctor's order; however, they stated they could not sleep and purchased the melatonin in hopes that it would help them sleep. Resident #1 stated no one at the facility had talked with them about the bottle of melatonin that had been found on the floor of their room. They revealed they could not remember if they had taken any of the Melatonin or not. Review of the Medication Administration Record (MAR), dated [DATE], revealed Resident #1 had been prescribed "Empagliflozin 2 milligrams (MGs) Oral Tablet Give 12.5 mgs at bedtime for insomnia."

	A review of the "Daily Participation Record" revealed Resident #1 had been taken by facility staff to shop at Wal-Mart on [DATE]. An interview, on 7/17/24, at 8:53 a.m., with Consultant Staff A revealed they had accompanied Resident #1 to Wal-Mart on [DATE]. They revealed Resident #1 was alert and oriented, so they had not necessarily looked over what they had purchased. Consultant Staff A stated they had not observed the resident purchase Melatonin, but if they had observed the resident purchase it, they would have tried to stop the resident from doing so. They revealed that typically staff would have alerted them of these types of incidents; however, they revealed they did not know anything about this incident with the Melatonin and Resident #1. They revealed that they expected staff to make them aware of these types of issues so they could more closely monitor what Resident #1 purchased while out shopping. In an interview, on 7/16/24, at 1:00 p.m., and again on 7/17/24, at 9:11 a.m., Administrative Nurse A revealed Resident #1 had never admitted to staff they had purchased the Melatonin at the store. They revealed the facility had not conducted an investigation related to the discovery of the Melatonin that had been found on Resident #1's floor. They went on to state that they did not know if the resident's room had been searched for any other supplements/medications. Administrative Nurse A revealed the Melatonin issue had not been discussed in the quarterly Quality Assurance Performance Improvement Committee (QAPI) meeting. An interview, on 7/17/24, at 11:31 a.m., with Administrative Staff A revealed they had not been made aware that a bottle of Melatonin had been found in Resident #1's room and stated, "I would like to have known that." They revealed that their expectation was that they be informed if there were un-prescribed medications found in a resident's room so the facility could address it with Administrative Nurse A and the physician. Administrative Staff A revealed the melatonin issue had not been discussed In Quality Assessment Performance Improvement (QAPI).
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and	Based on observations and interviews, the facility staff failed to distribute food under sanitary conditions. The facility served 15 trays to the residents' rooms with desserts and salads uncovered. This failure had the potential to affect all 15 residents who ate meals in their rooms. The findings include:

(3) Dispose of garbage and refuse properly. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Some	On 7/16/24, at approximately 12:05 p.m., during observations of the noon meal on both units, it was observed that five trays were passed without the salad, or the tiramisu dessert, covered. The food cart was left in the center of both units by the [LOCATION]. Staff came from both units to get the trays and walk them down to the residents' rooms. On 7/17/24, at 12:00 p.m., during observations of the noon meal on the units, it was observed that approximately 10 trays were passed out to the rooms without the dessert covered. On 7/17/24, at 1:00 p.m., in an interview with Dietary Staff A, they stated that they didn't realize all the food had to be covered while passing the trays to the residents who ate in their rooms. They stated that the facility had never done that. Dietary Staff A also stated the facility didn't have a policy addressing the issue. Dietary Staff A stated there were approximately ten to fifteen residents who ate meals in their rooms. On 7/18/24, at 1:00 p.m., in an interview with Administrative Staff B, they confirmed that the facility didn't have a policy for covering the food during tray pass down the hallways, but that the facility planned on getting a policy and fixing the situation.
§ 51.200 (a) Life safety from fire. (a) Life safety from fire. The facility must meet the applicable provisions of NFPA 101, Life Safety Code and NFPA 99, Health Care Facilities Code. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**Fire Safety and Operations** Based on records review and interview, the facility failed to conduct all required fire drills. The deficient practice affected four (4) of four (4) smoke compartments, staff, and all residents. The facility had the capacity for 50 beds with a census of 39 on the day of survey. The findings include: Records review, on 7/17/24, at 2:36 p.m., revealed that no documentation was present that indicated the facility had conducted any fire drills on the third shift (11:00 p.m., to 7:00 a.m.,) during the second quarter (April, May, or June) of 2024; on the second shift (3:00 p.m., to 11:00 p.m.,) during the fourth quarter (October, November, or December) of 2023; or on the third shift (11:00 p.m., to 7:00 a.m.,) during the fourth quarter (October, November, or December) of 2023, as required by section 19.7.1.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 7/17/24, at 2:36 p.m., revealed the facility was unaware that some fire drills were not conducted during some staff shifts. The census of 39 was verified by Administrative Staff A on 7/17/24, at 9:31 a.m. The finding was acknowledged by Administrative Staff A and verified by Administrative Staff C during the exit interview on 7/18/24, at 10:00 a.m.

	Actual NFPA Standard: NFPA 101 (2012) Life Safety Code **19.7.1.4 *** Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. **19.7.1.5** Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. **19.7.1.6** Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. **19.7.1.7** When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.