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, Anna, IL 62906

Onsite / Virtual: Onsite

Dates of Survey: 7/20/23 through 7/21/23

NH / DOM / ADHC: DOM

Survey Class: Annual

Total Available Beds: 12

Census on First Day of Survey: 7

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 20, 2023 through July 21, 2023 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.
§ 51.100 (c) Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on record review, interviews, and review of the facility policy, the facility management failed to have the resident council meet at least quarterly, affecting any resident who may have desired to attend. The findings include: Review of the resident's "Town Hall Meetings" revealed two (2) meetings were held in 2022 (April and September). Administrative Staff A revealed the residents stated they did not want to have any town hall meetings. The facility staff were asked to provide, in writing, the resident's request not to hold a resident council meeting. Administrative Staff A revealed the facility did not document the resident's request. On 7/21/23, at 9:30 a.m., Administrative Staff A revealed the residents preferred to have a "Town Hall" versus Resident Council, however the Town Hall meetings were still the same as resident council. Administrative Staff A stated they were

	unaware the residents should meet at least quarterly. Administrative Staff A stated they should have documented the residents' request to not meet quarterly.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observation, interview, and review of facility policy, the facility failed to ensure all drugs were in locked compartments where only authorized personnel with access to the keys had access for two (2) of two (2) residents reviewed who were self-administering medications (Resident #1 and Resident #2). The findings include: Review of facility policy titled, "Medication Self-Administration," and dated 8/22/22, revealed the purpose was: "to allow a resident to be able to keep and administer their own medications at their bedside or in their apartment." The policy did not include instructions for each resident to secure their medications in a provided lock box located on the wall in each apartment. 1. The facility admitted Resident #1 on [DATE], with the following diagnoses: Heart Disease, Type II Diabetes Mellitus, Hyperlipidemia, Osteoarthritis of the Knees, and Glaucoma. Observation of Resident #1, on 7/20/23, at 2:15 p.m., revealed the resident awake, alert, and oriented. They were noted to be sitting up in a recliner in their apartment, watching television. Continued observation revealed several brown bottles of medication on the resident's [LOCATION] counter. An interview, on 7/20/23, at 2:16 p.m., with Resident #1 revealed they administered their own medications daily and had not been made aware by the facility that their medications should be secured in a locked box. They stated as far as they knew, there was not a medication box in their room that could be locked. Resident #1 stated they would often go out in the hallway and sit, and that they did not lock their room door. Record review of the provider's orders, dated [DATE], revealed the resident had been prescribed the following medications: • Atenolol 25 milligrams (MG) daily for Hypertension • Simvastatin 40 MG daily for Hyperlipidemia • Metformin HCL 1000 MG twice a day for Diabetes Mellitus • Lumigan 0.01% one drop to both eyes daily for Glaucoma • Lisinopril 40 MG daily for Hypertension • Hydrochlorothiazide 25 MG daily for Hypertension • Glimepiride 4 MG daily for Diabetes Mellitus • Dorzolamide HCL 2% one drop to both eyes three times a day for Glaucoma

	• Combigan 0.2 % - 0.5% one drop to both eyes twice a day for Glaucoma • Aspirin 325 MG daily for coronary artery disease • Amlodipine 5 MG daily for Hypertension The facility could not provide evidence of a policy and procedure related to medication storage in the Domiciliary. 2. On 7/20/23, at 2:10 p.m., an observation of the apartment of Resident #2 revealed the door to the room was unlocked and a lock box was observed on the wall next to the [LOCATION]. The lock box was empty. Administrative Nurse A, who was present during the observation, stated they did not know where Resident #2 kept their medication but confirmed there were no medications in the lock box provided to secure medications. On 7/20/23, at 2:45 p.m., during an interview with Resident #2, they stated the medications were in a drawer located in the [LOCATION] of the apartment. Resident #2 stated the medications were dispensed on punch cards and the cards would not fit in the lock box, so they kept them in the drawer. Observation of the drawer in the [LOCATION] revealed five (5) medication cards containing: • Celecoxib 100 milligrams (mg) 21 capsules • Pantoprazole 20 mg 19 tablets • Levothyroxine 100 micrograms (mcg) 10 tablets • Cholecalciferol 50 mcg 19 tablets • Acetaminophen 500mg 21 slots containing 42 tablets Also observed in the drawer was a bottle of Carboxymethycellulose Sodium 0.5% eye drops. There were also two (2) medication cups each containing two (2) pills that were not identified. When questioned, Resident #2 stated those were medications they had prepared for the next morning. On 7/20/23, at 3:45 p.m., during a second interview with Administrative Nurse A, they stated the facility could not make residents use the lock boxes to store their medications. Administrative Nurse A also stated the facility could not force them to lock the door to their apartment. The medications observed in the apartment for Resident #2 were in an unlocked room in an unlocked drawer in the [LOCATION], and were available for access to anyone who might enter the apartment of Resident #2.
§ 51.210 (b) Disclosure of State agency and individual responsible for oversight of facility.	Based on record review and staff interview, the facility management failed to provide written notice of Administrative Staff B change in a timely manner. The census was seven (7).

Disclosure of State agency and individual responsible for oversight of facility. The State must give written notice to the Office of Geriatrics and Extended Care, VA Headquarters, 810 Vermont Avenue, NW, Washington, DC 20420, at the time of the change, if any of the following change: (1) The State agency and individual responsible for oversight of a State home facility; (2) The State home administrator; (3) The director of nursing services (or other individual in charge of nursing services); and (4) The State employee responsible for oversight of the State home if a contractor operates the State home **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The findings include: Review of the facility's Long-Term Care (LTC) [Administrative Staff B] Form, dated [DATE], revealed Administrative Staff B's start date was [DATE]. On 7/20/23, at 9:45 a.m., during an interview with Administrative Staff B, they revealed their effective date of hire was [DATE]. Administrative Staff B stated they contacted the Veterans Administration Central Office (VACO) on [DATE], to update the Administrative Staff B's change effective [DATE]. Administrative Staff B acknowledged the Office of Geriatrics and Extended Care (GEC) should have been notified at the time of change.
§ 51.210 (g) Staff qualifications. (1) The facility management must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. (2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	Based on record review and interviews, the facility failed to ensure the Veterans Administration (VA) 10-3567 Staffing Profile form was completed to accurately reflect the professional staff employed necessary to carry out the provisions of these requirements. The census was seven (7). The findings include: On 7/18/23, at 10:36 a.m., after the nursing home entrance conference with the facility staff, Administrative Staff B was sent the five (5) required VA forms for completion. Administrative Staff B was advised to address the survey team with any questions or concerns regarding the completion of the forms. Administrative Staff B was informed the survey team would like the VA 10-3567 Staffing Profile Form completed by day two (2) of the survey. On 7/19/23, at 3:09 p.m., the survey team received physical copies of the VA 10-3567 Staffing Profile Form. The form was reviewed and there were several areas of concern. Please see the following: 1. The Full Time Employee Equivalents (FTEE) Authorized for the DOM and Total Facility was incorrect. 2. The FTEE Available for the DOM and Total Facility was incorrect. On 7/19/23, at 3:24 p.m., the survey team received the VA-10-3567 Staffing profile form, via email. Review of the form

	revealed several errors in Parts I, II, and V. Administrative Nurse B was advised to review the form again for accuracy. Administrative Nurse B stated they completed part V and would review the forms again for accuracy. Administrative Nurse B revealed Administrative Staff B completed Parts I and II and would take a look at the form again. During this time, Administrative Nurse B was advised to provide the survey team with any questions or concerns regarding the VA 10-3567 Staffing Profile Form. On 7/20/23, at 9:00 a.m., the survey team asked Administrative Nurse A and Administrative Nurse B whether they needed assistance with completing the Staffing Profile Form. Administrative Nurse B revealed they were still working on revising the form and would address the survey team for assistance. At this time, the survey team gave the facility examples of errors that needed to be revised. Administrative Staff B, Administrative Nurse A, and Administrative Nurse B stated they would revise the form and get it to the survey team as soon as possible. On 7/20/23, at 1:19 p.m., the survey team received another copy of the Staffing Profile Form via email. The survey team exited the Nursing Home and had entered the DOM by the time the Staffing Profile Form was sent. Review of the Staffing Profile form revealed Part I and II had been completed. The survey team was unable to verify if Part V was accurate. On 7/21/23, at 10:00 a.m., Administrative Staff B, Administrative Nurse A, and Administrative Nurse B were advised the survey team had not received an accurate Staffing Profile Form during the survey. The survey team was unable to verify the accuracy of the form during the survey.
§ 51.300 (b) Work. The resident must participate, based on his or her ability, in some measure, however slight, in work assignments that support the maintenance and operation of the State home. The State Home management must create a written policy to implement the work requirement. The resident is encouraged to participate in vocational and employment services, which are essential to meeting the psychosocial needs of the resident. The resident must perform work for the facility after the State home has accomplished the following: (1) The facility has documented the	Based on interview and record review, the facility failed to create a written policy to implement the work requirement. The facility further failed to ensure each resident participated in a work assignment that supported the maintenance and operations of the state home for all residents in the facility. The findings include: On 7/20/23, at 4:45 p.m., during an interview with Administrative Staff A, they stated each resident signed a document on admission stating whether or not they wished to participate in the work assignments. Administrative Staff A stated that currently, all seven (7) residents in the facility had declined to participate in the work assignment program. Administrative Staff A stated they would try to locate a policy regarding work assignments for residents in the facility.

resident's need or desire to work in the comprehensive care plan; (2) The comprehensive care plan described in § 51.310 specifies the nature of the work performed and whether the work is unpaid or paid; (3) Compensation for work for which the facility would pay a prevailing wage if done by non-residents is paid at or above prevailing wages for similar work in the area where the facility is located; and (4) The facility consulted with and the resident agrees to the work arrangement described in the comprehensive care plan. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Review of a facility form provided to residents on admission, revealed the following documentation: "As part of the Illinois Veterans Home—Anna Domiciliary Work Program, I understand that I have been given the opportunity to work any of the below assignments pertaining to the maintenance and operation of the home: Mop and sweep floors; Sweep outside sidewalks; Clean tables in the [LOCATION] after meals; Work in [LOCATION] (When Open); Wash Windows; and Wash agency vehicles." The form continued and provided a space for a resident to sign to either "decline the opportunity" or "wish to volunteer for these services." A place for resident signatures and a place for Consultant Staff A's signature was located at the bottom of the form. The facility admitted Resident #1 on [DATE], with the following diagnoses: Heart Disease, Type II Diabetes Mellitus, Hyperlipidemia, Osteoarthritis of the Knees, and Glaucoma. Observation of Resident #1, on 7/21/23, at 8:30 a.m., revealed the resident awake, alert, and oriented. They were noted to be sitting up in a recliner in their apartment. An interview with the resident, on 7/21/23, at 9:00 a.m., revealed they did not recall the facility offering them any work on admittance. Resident #1 stated they had vision loss and required the use of a rolling walker for mobility. Review of the document, no title, which addressed the Domiciliary Work Program, no date, and signed by Consultant Staff A, and the resident's power of attorney (POA), no date, revealed the options for work upon their admission were as follows: Mop/Sweep the floors, Sweep the Outside Sidewalks, Clean Tables in the [LOCATION] after Meals, Work in the [LOCATION] When Open, Wash Windows, or Wash Agency Vehicles. Review of Resident #1's Service Plan, dated [DATE], did not reveal a focus of "work." The facility could not provide a policy and procedure on "work." On 7/20/23, at 2:10 p.m., during an interview with Administrative Nurse A, they stated residents in the facility did not have jobs/work assignments. Administrative Nurse A stated they did not think the facility had a policy to address work assignments for residents in the facility. Review of the medical record for Resident #2 revealed an admission date of [DATE]. Diagnoses included Osteoarthritis, Diverticulitis, Vitamin D Deficiency, Benign Prostatic Hyperplasia, and Hypothyroidism.

	On 7/20/23, at 2:45 p.m., during an observation and interview with Resident #2, the resident was observed in their room and was alert to person, place, and time. They stated they could not remember talking to anyone about a work assignment. They stated they would keep the apartment clean because it was their home, and they liked a clean house. On 7/21/23, at 9:10 a.m., Administrative Staff A stated they were not able to locate a policy regarding work assignments for residents in the facility, but would continue to look for one and provide it, if one was located. Administrative Staff A stated they were not able to locate the form for Resident #2 which was provided on admission, which offered them a work assignment, and showed that they had declined to participate. On 7/21/23, at 9:15 a.m., during an interview with Administrative Staff B, they stated the facility did not have a policy regarding work assignments for residents in the facility. The facility failed to develop a written policy for implementing the work requirement. The facility further failed to ensure each resident participated in a work assignment that supported the maintenance and operations of the state home for all residents in the facility.