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: Virtual

Dates of Survey: 7/11/22-7/13/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 50

Census on First Day of Survey: 35

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 11, 2022, through July 13, 2022, at the Illinois Veterans Home - Anna. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.110 (e) (1) Comprehensive care plans. The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70,	Based on interviews, record review, and review of facility policy, it was determined the facility did not complete a Quarterly Minimum Data Set (MDS) Assessment for two (2) of seven (7) residents reviewed (Resident #5 and Resident #6). The findings include: Review of the facility policy titled, "MDS," dated 5/1/18, documented that the MDS 3.0 section C (cognition part of the assessment) was the responsibility of Social Services. Review of Resident #5's clinical record revealed an admission date in 2021 and a readmission date in 2022. The diagnoses included: Cerebral Infarction, Fracture of Right and Left Lower Leg, Seizures, Chronic Kidney Disease Stage Three (3) and Major Depressive Disorder. Review of Resident #5's Quarterly MDS Assessment dated [DATE] documented that the Brief Interview for Mental Status (BIMS) should have been conducted. Review of the

including the right to refuse treatment under §51.70(b)(4) of this part. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	BIMS/cognition status revealed the 12 questions that were included were not assessed. Review of Resident #6's clinical record revealed an admission date in 2022 and the diagnoses included: Major Depressive Disorder, Anxiety, and Arteriosclerotic Heart Disease. Review of Resident #6's Quarterly MDS Assessment dated [DATE] documented that the Brief Interview for Mental Status (BIMS) should have been conducted. Review of the BIMS/cognition status revealed the 16 questions that were included were not assessed. In an interview with Licensed Nurse A on 7/12/22, at 2:21 p.m., they stated that the facility did not have Social Service staff in the building from the end of December, 2021 to the beginning of May, 2022 and they were instructed to not complete the cognition assessment. In an interview with Administrative Staff A on 7/12/22 at 4:05 p.m., they confirmed that the facility did not have Social Service staff in the building on a daily basis, from the end of December to the first (1st) of May, but were unaware of the directive to not complete the resident's cognition assessment on the MDS.
§ 51.120 (n) Medication Errors The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	Based on observation, interviews, record reviews, and review of the facility policy, it was determined that the facility failed to follow the Physician Order for the dosage of an inhaler for one (1) resident (Resident #9) and failed to administer eye drops appropriately for one (1) resident (Resident #10) of the four (4) residents observed during the Medication Pass. The findings include: Review of the facility policy titled, "Medication Administration," dated 4/13/18, documented: "Procedure: ADMINISTRATION OF EYE DROPS 7. Drop medication into the conjunctiva sac of lower lid and instruct member to close eyes gently. Ensure the drop is properly instilled. The eye drop, not the dropper must make full contact with the conjunctiva sac and then be washed over the eye. The eye drop must contact the eye for a sufficient period of time before the next eye drop is instilled. The time for optimal eye drop absorption is [three] 3-[five] 5 minutes apart. It is considered a medication error if this is not done. Procedure: 28. A Medication error is defined as the observed preparation or administration of drugs or biological which are not in accordance with: a. Physician's orders. b. Manufacturer' s specifications regarding the preparation and administration of the drug or biological. c. Accepted professional standards and principles which apply to professionals providing services."

	Review of the "US Pharmacist, Patient Teaching Aide regarding How to Administer Eye Drops Properly," dated 2003, documented: "6. Close the eye gently for one (1) to three (3) minutes to allow the medication to be absorbed. Some doctors recommend pressing the finger in the inner corner of the eye to prevent the eye drop from going into the tear duct." Observation on 7/12/22, at 8:01 a.m., revealed Licensed Nurse B administered medications to Resident #9. Observation at that time revealed Licensed Nurse B handed Resident #9 the Olodaterol Tiotropium inhaler (used to treat Chronic Obstructive Pulmonary Disease/COPD) and instructed them to breathe fully out, administer one (1) puff of the inhaler, and hold their breath for 10 seconds. Licensed Nurse B then took the inhaler back and continued to administer the resident's other medication. Review of Resident #9's Physician Order revealed an order for Olodaterol Tiotropium inhaler, two (2) puffs daily. In an interview with Licensed Nurse B on 7/12/22, at 11:33 a.m., they confirmed that the resident should have received two (2) puffs of the inhaler every day. Observation on 7/12/22, at 12:46 p.m., revealed Licensed Nurse C administered medications to Resident #10. Observation at that time revealed Licensed Nurse C administered Brimonidine Tartrate (used to treat glaucoma with systemic effects) 0.15 percent (%) to the resident. Licensed Nurse C administered one (1) drop into each eye and blotted the eyes with a tissue, which would soak up any or some of the medicine, and then continued to administer the other medications without holding the inner canthus of the eye or instructing the member to keep their eyes closed. In an interview with Licensed Nurse C on 7/12/12, at 12:54 p.m., they stated that they did not know they had to hold the inner canthus or have the member close their eyes after administering the eye drops. In an interview with Licensed Nurse A on 7/12/22, at 12:57 p.m., they stated that it would be written in the orders if the nurse should hold the inner canthus after administering the eye drops. Licensed Nurse A stated that they did not know if the staff should hold the inner canthus of the eye or instruct the member to keep their eyes closed after the administration of the Brimonidine Tartrate eye drops. They further stated that the nurses do not get the package inserts from the pharmacy to refer to.

§ 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 (3) Dispose of garbage and refuse properly. Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	Based on observations, interviews, and review of the facility's policy, the facility failed to ensure food was stored, prepared, and served under sanitary conditions by evidence of staff failing to wear hair nets appropriately in the kitchen. These sanitary concerns were observed in one (1) of one (1) kitchen used to serve food. This deficient practice could place all residents who receive food from the kitchen at risk for unsanitary eating conditions. The findings include: Record review of the facility's policy titled, "Hair Restraints," revealed, "Procedure: 1. Staff shall wear hair restraints in all food production, dishwashing and serving areas." Observation of Administrative Nurse A on 7/11/22, at 10:46 a.m., revealed that they walked into the kitchen without a hair net and did not obtain one from the kitchen upon entry. Administrative Nurse A was the liaison for the surveyor and walked through the kitchen during lunch preparation. Observation of Administrative Nurse A on 07/12/22, at 11:51 a.m., revealed that they walked into the kitchen without a hair net. Administrative Nurse A was observed standing next to the lunch serving line when Administrative Nurse A was handed a hair net by an unknown kitchen staff member. An interview with Administrative Nurse A on 7/13/22, at 11:10 a.m., revealed that the hair nets in the kitchen were located inside of the kitchen. They stated that one must ask for a hair net if they were not located at the door. In an interview with Dietary Staff A on 7/13/22, at 11:12 a.m., revealed that they expected all staff to wear a hair net while in the kitchen. They stated that staff normally ask for what they need and don't enter the kitchen. They stated that the hair nets were in the kitchen.
§ 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	Based on records review, observation and interview, the facility failed to properly inspect and test the hospital grade electrical receptacles in patient care areas. The deficient practice affected five (5) of five (5) smoke compartments, staff, and all residents. The facility had a capacity for 50 beds with a census of 35 on the day of the survey. The findings include: Records review on 7/12/22, at 11:15 a.m., revealed there was no documentation of testing of hospital grade receptacles in patient care areas at intervals defined by documented

	performance data, as required by section 6.3.4.1.2 of NFPA 99 Health Care Facilities Code. Observation during the tour of the facility on 7/13/22, at 11:48 a.m., revealed hospital grade electrical receptacles in resident rooms and physical therapy area. An interview at the time with Maintenance Staff A revealed that the facility was recently made aware of the requirements for receptacle testing but had yet to implement a program. The census of 35 was verified by Maintenance Staff A on 7/12/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 7/14/22. **Actual NFPA Standard: NFPA 99 2012 Health Care Occupancies Chapter 6 Electrical Systems** **6.3.4.1** Maintenance and Testing of Electrical System. **6.3.4.1.1** Where hospital-grade receptacles are required at patient bed locations and in locations where deep sedation or general anesthesia is administered, testing shall be performed after initial installation, replacement, or servicing of the device. **6.3.4.1.2** Additional testing of receptacles in patient care rooms shall be performed at intervals defined by documented performance data.