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: 7/18/23 through 7/20/23

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 50

Census on First Day of Survey: 44

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from July 18, 2023 through July 20, 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.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and (ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observation, record review, and interview, the facility failed to ensure the services provided met professional standards of quality by failing to follow Physician Orders for one (1) of four (4) residents observed during medication administration observation (Resident #11). The findings include: Review of the facility policy "Physician's Orders," dated 2/21/2020, revealed there was no guidance for facility staff to administer medications as ordered or to follow special instructions ordered by the physician for each specific medication. On 7/19/23, at 8:30 a.m., during observation of medication administration, Licensed Nurse A administered medication to Resident #11 to include Mometasone Furoate Aerosol 100 micrograms (mcg)/actuator(act)-give two (2) puffs, inhale orally

	two (2) times a day for breathing. The label included instructions to shake well, rinse mouth out with water and spit after each dose, and clean mouthpiece with dry wipe. Licensed Nurse A was observed to administer two puffs of Mometasone Furoate via an inhaler device waiting two (2) minutes between each puff. Licensed Nurse A did not provide water or instruct Resident #11 to rinse and spit after each dose, nor did they clean the mouthpiece with a dry wipe after use. On 7/19/23, at 8:45 a.m., during an interview with Licensed Nurse A after completion of medication administration observation, they confirmed Resident #11 was not provided with water to rinse and spit after using the inhaler medication. Licensed Nurse A also confirmed that they did not clean the mouthpiece with a dry wipe after use of the device. Review of the medical record for Resident #11 revealed a Physician Order, dated [DATE], that read as follows: "Mometasone Furoate Aerosol 100 mcg/act. two (2) puffs inhale orally two (2) times a day for breathing, shake well, rinse mouth out with water and spit after each dose, clean mouthpiece with dry wipe." Licensed Nurse A failed to follow the Physician Orders by failing to provide water and instructing Resident #11 to rinse their mouth and spit the water out after each dose of the inhaled medication administered. Licensed Nurse A also failed to clean the mouthpiece of the inhaler before placing it in the storage bag and returning it to the medication cart.
§ 51.130 (d) Nursing services. The facility management must provide nursing services to ensure that there is direct care nurse staffing of no less than 2.5 hours per patient per 24 hours, 7 days per week in the portion of any building providing nursing home care. **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	Based on observation, record review, and interview, the facility failed to maintain direct care nurse staffing levels of at least 2.5 hours per patient as required. The findings include: On 7/19/23, at 3:24 p.m., the survey team received the VA-103567 Staffing profile form, via email. Review of the form revealed several errors in Parts I, II, IV and V. Administrative Nurse A was advised to review the form again for accuracy. Administrative Nurse A stated they completed parts IV and V and would review the forms again for accuracy. Administrative Nurse A revealed Administrative Staff A completed Parts I and II and would take a look at the form again. During this time, Administrative Nurse A 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. Administrative Nurse A 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 A, Administrative Nurse B, and Administrative Nurse A 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. Review of Part IV revealed direct care hours of 1.92, which is under the 2.5 recommended patient to nursing care hours. Administrative Nurse A was sent the form again to review for accuracy. On 7/21/23, at 10:00 a.m., Administrative Staff A, Administrative Nurse B, and Administrative Nurse A 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.
§ 51.140 (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 observation, interview, and policy review, the facility failed to prepare food under sanitary conditions. Staff were observed to handle food without donning gloves, which could affect all residents who received pureed meals. The findings include: Review of the policy and procedure titled, “Staff Fundamentals for Serving Food,” dated 8/27/18, revealed: “Gloves are treated like a food contact surface. Gloves are used anytime ready to eat foods must be touched by a hand…A bare hand is never used to touch ready to eat foods.” Observation of Dietary Staff A, on 7/19/23, at 11:04 a.m., revealed them preparing pureed ribs in the blender. Continued observation revealed Dietary Staff A used their bare hands to place bread into the blender bowl that contained the rib meat. An interview with Dietary Staff A, on 7/19/24, at 11:05 a.m., revealed sometimes they did not wear gloves when handling food if they had just washed their hands. An interview with Dietary Staff B, on 7/19/23, at 11:07 a.m., and on 7/20/23, at 8:59 a.m., revealed staff should wear gloves anytime food was being handled with their bare hands, and Dietary Staff A should have been wearing gloves when they

	handled the bread. Dietary Staff B went on to state that the pureed ribs would have to be thrown out and new ribs prepared. They stated staff should always wear gloves when handling food to prevent possible cross contamination. Dietary Staff B stated in-services on food handling were presented at least once a month by either them, or by Dietary Staff C.
§ 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** – Some	**Smoke Barrers and Sprinklers** 1. Based on observation and interview, the facility failed to maintain corridor doors to resist the passage of smoke. The deficient practice affected one (1) of four (4) smoke compartments, staff, and four (4) residents. The facility had a capacity for 50 beds with a census of 44 on the day of the survey. The findings include: Observation during a tour of the building, on 7/20/23, at 10:41 a.m., revealed the corridor door to the [LOCATION] had a transfer grill of approximately 14X8 inches in size in the lower half of the door. Additional observation revealed the transfer grill was not equipped with a built-in fire damper. The transfer grill prevented the door from resisting the passage of smoke as required by section 19.3.6.3.2(2) of NFPA 101 Life Safety Code. An interview, on 7/20/23, at 10:41 a.m., with Administrative Staff B revealed the facility was not aware the door to the [LOCATION] was required to resist the passage of smoke. The census of 44 was verified by Administrative Staff A on 7/20/23, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Administrative Staff B during the exit interview on 7/20/23, at 1:30 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.6.3*** Corridor Doors. **19.3.6.3.1*** Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following: **(1)** 13/4 in. (44 mm) thick, solid-bonded core wood **(2)** Material that resists fire for a minimum of 20 minutes **19.3.6.3.2** The requirements of 19.3.6.3.1 shall not apply where otherwise permitted by either of the following: **(1)** Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to comply with 19.3.6.3.1.

	(2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, the door construction materials requirements of **19.3.6.3.1** shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. **19.3.6.3.3** Compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives, shall not be required. **19.3.6.3.4** A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. **19.3.6.3.4** A clearance between the bottom of the door and the floor covering not exceeding 1 in. (25 mm) shall be permitted for corridor doors. **19.3.6.3.5*** Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: **(1)** The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. **(2)** Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. 2. Based on observations and interview, the facility failed to provide the required separation of hazardous areas from other areas of the facility. The deficient practice affected one (1) of four (4) smoke compartments, staff, and four (4) residents. The facility had a capacity for 50 beds with a census of 44 on the day of the survey. The findings include: Observation during a tour of the building, on 7/20/23, at 11:14 a.m., of [LOCATION], revealed the door had two (2) 1.5 inch diameter holes near the door handle that went all the way through the door. The room was in excess of 50 square feet and contained multiple cardboard boxes containing supplies. The door was not smoke resistive and free from holes as required by section 5.2.4.2(1) of NFPA 80, Standard for Fire Doors and Other Opening Protectives. An interview, on 7/20/23, at 11:14 a.m., with Administrative Staff B revealed the facility was not aware of the holes in the door. The census of 44 was verified by Administrative Staff A on 7/20/23, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Administrative Staff B during the exit interview on 7/20/23, at 1:30 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)**

	19.3.2 Protection from Hazards. **19.3.2.1 Hazardous Areas.** Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. **19.3.2.1.1** An automatic extinguishing system, where used in hazardous areas, shall be permitted to be in accordance with 19.3.5.9. **19.3.2.1.2*** Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. **19.3.2.1.3** The doors shall be self-closing or automatic-closing. **Actual NFPA Standard: NFPA 101 (2012) Life Safety Code** **19.3.2.1 Hazardous Areas.** Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.7.1. **19.3.2.1.2*** Where the sprinkler option of 19.3.2.1 is used, the areas shall be separated from other spaces by smoke partitions in accordance with Section 8.4. **8.4 Smoke Partitions.** **8.4.1* General.** Where required elsewhere in this *Code*, smoke partitions shall be provided to limit the transfer of smoke. **8.4.3 Opening Protectives.** **8.4.3.1** Doors in smoke partitions shall comply with 8.4.3.2 through 8.4.3.5. **8.4.3.2** Doors shall comply with the provisions of 7.2.1. **8.4.3.3** Doors shall not include louvers. **8.4.3.4*** Door clearances shall be in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. **Actual NFPA Standard: NFPA 80, Standard for Fire Doors and Other Opening Protectives (2010)** **5.1.5 Repairs and Field Modifications.** **5.1.5.1** Repairs shall be made, and defects that could interfere with operation shall be corrected without delay. **5.2* Inspections.** **5.2.1*** Fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. **5.2.3 Functional Testing.** **5.2.3.1** Functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. **5.2.3.2** Before testing, a visual inspection shall be performed to identify any damaged or missing parts that can create a hazard during testing or affect operation or resetting. **5.2.4 Swinging Doors with Builders Hardware or Fire Door Hardware.**

	5.2.4.1 Fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. **5.2.4.2** As a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame.
§ 51.200 (h) (1) Other environmental conditions. The facility management must provide a safe, functional, sanitary, and comfortable environment for the residents, staff and the public. The facility must— (1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Some	Based on observations and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment to residents, staff, and the public. The deficient practice affected one (1) of four (4) smoke compartments, staff, and 12 residents. The facility had a capacity for 50 beds with a census of 44 on the day of the survey. The findings include: Observation during a tour of the building, on 7/20/23, at 8:40 a.m., of the [LOCATION] near the [LOCATION], revealed the following: - Two (2) floor tiles under the urinal were loose and not secured in place. - The privacy dividers separating the urinal from adjoining spaces showed visible signs of rust at the bottom of the dividers. - The two (2) built-in soap dishes in the walls near the hand washing sinks both showed visible signs of rust. An interview, on 7/20/23, at 8:40 a.m., with Administrative Staff A revealed they were not aware of the loose floor tiles or the rust on the privacy divider walls or soap dishes in the [LOCATION], but plans were being made to obtain funding to remodel the [LOCATIONS] near the [LOCATIONS]. Observation during a tour of the building, on 7/20/23, at 10:59 a.m., of a [LOCATION] on the [LOCATION], revealed the [LOCATION] inside the [LOCATION] had a two-foot by three-foot rectangular hole cut in the ceiling. An interview, on 7/20/23, at 10:59 a.m., with Administrative Staff B revealed the facility was not aware of the rectangular hole cut in the ceiling of the [LOCATION]. The census of 44 was verified by Administrative Staff A on 7/20/23, at 9:30 a.m. The findings were acknowledged by Administrative Staff A and verified by Administrative Staff B during the exit interview on 7/20/23, at 1:30 p.m.
§ 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 the Administrative Staff A change in a timely manner. The census was 44.

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 A] Form, dated [DATE], revealed Administrative Staff A's start date was [DATE]. On 7/20/23, at 9:45 a.m., during an interview with Administrative Staff A, they revealed their effective date of hire was [DATE]. Administrative Staff A stated they contacted the Veterans Administration Central Office (VACO) on [DATE], to update the Administrative Staff A change effective [DATE]. Administrative Staff A 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 for the entire facility. The findings include: On 7/18/23, at 10:36 a.m., after the entrance conference with the facility staff, Administrative Staff A was sent the five (5) required VA forms for completion. Administrative Staff A was advised to address the survey team with any questions or concerns regarding the completion of the forms. Administrative Staff A 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 Equivalent (FTEE) Authorized for the NHC and Total Facility was incorrect. 2. The FTEE Available for the NHC and Total Facility was incorrect. On 7/19/23, at 3:24 p.m., the survey team received the VA-103567 Staffing profile form, via email. Review of the form

	revealed several errors in Parts I, II, IV and V. Administrative Nurse A was advised to review the form again for accuracy. Administrative Nurse A stated they completed parts IV and V and would review the forms again for accuracy. Administrative Nurse A revealed Administrative Staff A completed Parts I and II and would take a look at the form again. During this time, Administrative Nurse A 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 B and Administrative Nurse A did they needed any assistance with completing the Staffing Profile Form. Administrative Nurse A 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 A, Administrative Nurse B, and Administrative Nurse A 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. Review of Part IV revealed direct care hours of 1.92, which was under the 2.5 recommended patient to nursing care hours. Administrative Nurse A was sent the form again to review for accuracy. On 7/21/23, at 10:00 a.m., Administrative Staff A, Administrative Nurse B, and Administrative Nurse A 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.