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 at Chicago

Location: 4250 N. Oak Park Ave., Chicago, IL 60634

Onsite / Virtual: Onsite

Dates of Survey: 6/16/25 – 6/18/25

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 200

Census on First Day of Survey: 56

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from June 16, 2025, through June 18, 2025, at the Illinois Veterans Home – Chicago. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.140 (c) Menus and nutritional adequacy. Menus must— (1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; (2) Be prepared in advance; and (3) Be followed **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	Based on observation and interview, it was determined that the facility failed to ensure the pureed diets and regular diets received bread according to the menu. This failed practice affected all three (3) residents receiving pureed diets, and all residents on regular diets who didn't receive bread as listed on the menu for two (2) of three (3) days during the survey. This failed practice had the potential to affect all 56 residents eating meals out of the [LOCATION]. The findings include: Review of the facility policy, "Principals and Guidelines Used in Menu Planning," dated 2017, documented: "In general, with the proper selection of foods and following the minimum daily menu components, the current Dietary Reference Intakes/Recommended Dietary Allowances/Adequate intakes, Food and Nutrition Board, Institute of Medicine, National Academy of Science, 2011 for individuals ages 31 years and older will be met. The minimum Daily Menu Components employed in menu planning include: …6 servings of Grains/Starches or more- one serving is equivalent to one slice

	of bread, ½ bagel, ½ English muffin, ½ hamburger bun, ½ hot dog bun, one biscuit, three graham crackers, six saltines, ¾ cup dry cereal, ½ cup cooked cereal, ½ cup cooked rice or pasta, two cookies, one serving cake, one donut, or one muffin." Review of the noon meal menu, dated 6/16/25, documented that all the diets were to receive garlic bread with their meal. During the lunch observation, on 6/16/25, from 12:49 p.m., to 1:13 p.m., on the [LOCATION], the nine (9) residents did not receive bread with their meals. Resident #4 said: "I didn't get bread; no I don't know why!" Review of the noon menu, dated 6/17/25, revealed the pureed diets were supposed to receive a pureed BBQ pork chop, mashed potatoes and gravy, pureed seasoned corn, pureed peach cobbler, and pureed wheat bread with a beverage. Observation of the preparation of the noon meal, at 11:00 a.m., on 6/17/25, revealed that the Dietary Staff A prepared the meat in the blender, sanitized the blender, then pureed the corn. After sanitizing the blender, Dietary Staff A then pureed the potatoes. Dietary Staff A was not observed to puree bread. When asked about the pureed bread, they explained that it wasn't on the tally sheet, which meant that no one ordered pureed bread. During the tray line meal service, on 6/17/25, at 12:00 p.m., it was observed that the three (3) pureed trays received pureed meat, peas, and mashed potatoes. The pureed trays also had pureed dessert. Pureed bread was not served to them. It was also observed that the regular diets didn't receive wheat bread as printed on the menu. Observations of the actual tray tickets for the noon meal found that they didn't list bread as an option to be served. On 6/17/25, at 2:00 p.m., in an interview with Dietary Staff A, they stated that the tray tickets didn't list bread as an option, which was the reason the residents didn't order it. Thus, it wasn't listed on the tally. On 6/17/25, at 2:30 p.m., in an interview with Administrative Staff B, they stated that the new menu system was started in February, and they were still trying to iron out some of the problems. They acknowledged that the bread was supposed to be served.
§ 51.140 (h) Sanitary conditions.	Based on observations and interviews, the facility staff failed to properly monitor the "Residents Refrigerator," in which the

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** – Some	resident and family could keep food. There were items in the refrigerator that were not labeled or dated. This had the potential to affect three (3) units out of five (5) units occupied by residents ([LOCATIONS]). The findings include: The facility policy "Food Brought into the Facility" revised 12/22, documented the following: "It is the policy of this facility to prepare and deliver food safely to our residents, families, and staff. This policy will ensure proper handling, serving and storage of any food items brought into our facility from all outside sources. 3. Procedure…C. Visitors (Family/Friends) 1. When visitors bring food into a specific resident, the following rules must be followed: …f. All food items brought in for a resident that requires storage in the facilities refrigerator will be marked with the Residents name, the date the food item was received for storage and a date to be discarded." On 6/16/25, the following was observed in the Residents Refrigerator: • At 1:17 p.m., on [LOCATION]: A mason jar containing a pink/red liquid was undated with no label; two (2) granny smith apples were in a bag with no label or date; a pizza box, which was dated 6/8/25, and not with the two dates required by the policy. • At 1:25 p.m., on [LOCATION]: an open bag of donuts, dated 5/31, with no resident's name on it; a plastic grocery bag containing food which was not labeled or dated; a plastic bag, which appeared to be from a Mexican restaurant, was not labeled or dated. On 6/17/25, the following was observed in the Residents Refrigerator: • At 12:25 p.m., on [LOCATION]: A semi wrapped sandwich was not dated or labeled; a purse was observed in the refrigerator; a mason jar containing pink/red liquid was not labeled or dated; an open bag of Chicken Alfredo was in the freezer and not labeled or dated. • At 12:35 p.m., on [LOCATION]: an open bag of donuts, dated 5/31, with no resident's name on it; a plastic grocery bag containing food which was not labeled or dated; a plastic bag, which appeared to be from a Mexican restaurant, was not labeled or dated.

	• At 12:46 p.m., on [LOCATION]: A sauce dish covered with foil was not labeled or dated. On 6/17/25, at 4:10 p.m., in an interview with Administrative Staff A, they acknowledged that the items in the Residents Refrigerator should be monitored more closely. They stated that it was the responsibility of the nursing staff to monitor those refrigerators.
§ 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	**<u>Means of Egress</u>** Based on observation and interview, the facility failed to provide the required signage for delayed egress doors. The deficient practice affected 12 of 24 smoke compartments, staff, and 56 residents. The facility had a capacity for 200 beds with a census of 56 on the day of the survey. The findings include: A. Observation, on 6/17/25, at 9:09 a.m., revealed the exit stairway door on the [LOCATION], across from the elevator, was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 6/17/25, at 9:09 a.m., revealed that the facility was unaware that the sign had to be on the door. B. Observation, on 6/17/25, at 9:14 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 6/17/25, at 9:14 a.m., revealed the facility was unaware the sign had to be on the door. C. Observation, on 6/17/25, at 9:19 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:19 a.m., revealed the facility was unaware that the sign had to be on the door.

D. Observation, on 6/17/25, at 9:29 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:29 a.m., revealed the facility was unaware the sign had to be on the door.

E. Observation, on 6/17/25, at 9:37 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:37 a.m., revealed the facility was unaware the sign had to be on the door.

F. Observation, on 6/17/25, at 9:40 a.m., revealed the exit stairway door on the [LOCATION], across from the elevator, was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:40 a.m., revealed the facility was unaware the sign had to be on the door.

G. Observation, on 6/17/25, at 9:44 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door

indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:44 a.m., revealed the facility was unaware the sign had to be on the door.

H. Observation, on 6/17/25, at 9:46 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:46 a.m., revealed the facility was unaware the sign had to be on the door.

I. Observation, on 6/17/25, at 9:52 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:52 a.m., revealed the facility was unaware the sign had to be on the door.

J. Observation, on 6/17/25, at 9:55 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 9:55 a.m., revealed the facility was unaware the sign had to be on the door.

K. Observation, on 6/17/25, at 9:57 a.m., revealed the exit stairway door on the [LOCATION], across from the

	elevator, was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 6/17/25, at 9:57 a.m., revealed the facility was unaware the sign had to be on the door. L. Observation, on 6/17/25, at 10:00 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 6/17/25, at 10:00 a.m., revealed the facility was unaware the sign had to be on the door. M. Observation, on 6/17/25, at 10:02 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 6/17/25, at 10:02 a.m., revealed the facility was unaware the sign had to be on the door. N. Observation, on 6/17/25, at 10:07 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 6/17/25, at 10:07 a.m., revealed the facility was unaware the sign had to be on the door.

O. Observation, on 6/17/25, at 10:09 a.m., revealed the stairway exit door on the [LOCATION], at the end of [LOCATION], was equipped with a delayed egress locking system. Additional observation at that time revealed that there were no signs affixed to the door indicating it was delayed egress, as required by section 7.2.1.6.1.1 (4) of NFPA 101, Life Safety Code.

An interview with Maintenance Staff A, on 6/17/25, at 10:09 a.m., revealed the facility was unaware the sign had to be on the door.

The census of 56 was verified by Administrative Staff A on 6/16/25, at 9:50 a.m. The findings were acknowledged by Maintenance Staff A and verified by Administrative Staff A during the exit interview on 6/17/25, at 4:00 p.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted by one of the following:
(1) Locks complying with 19.2.2.2.5 shall be permitted.
(2)*Delayed-egress locks complying with 7.2.1.6.1 shall be permitted.
(3)*Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.
(4) Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted.
(5) Approved existing door-locking installations shall be permitted.
7.2.1.6.1 Delayed-Egress Locking Systems.
7.2.1.6.1.1 Approved, listed, delayed-egress locking systems shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6 or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided that all of the following criteria are met:
(1) The door leaves shall unlock in the direction of egress upon actuation of one of the following:
(a) Approved, supervised automatic sprinkler system in accordance with Section 9.7
(b) Not more than one heat detector of an approved, supervised automatic fire detection system in accordance with Section 9.6
(c) Not more than two smoke detectors of an approved,

	supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3)*An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. (4)*A readily visible, durable sign in letters not less than 1 in. (25 mm) high and not less than 1⁄8 in. (3.2 mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTILALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS (5) The egress side of doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with Section 7.9. **Electrical Systems** Based on observation and interview, the facility failed to properly store oxygen cylinders. The deficient practice affected one (1) of 24 smoke compartments, staff, and 57 residents. The facility had the capacity for 200 beds with a census of 56 on the day of the survey. The findings include: Observation during the building inspection tour, on 6/17/25, at 9:56 a.m., revealed the [LOCATION] located on the [LOCATION] had two (2) E sized oxygen cylinders stored on the floor. The cylinders were not properly chained or supported, as required by sections 11.6.2.3 of NFPA 99, Health Care Facilities Code. An interview, on 6/17/25, at 9:56 a.m., with Maintenance Staff A revealed the facility was unaware the cylinders were not in a rack. The census of 56 was verified by Administrative Staff A on 6/16/25, at 9:50 a.m. The findings were acknowledged by

	Maintenance Staff A and verified by Administrative Staff A during the exit interview on 6/17/25, at 4:00 p.m. **Actual NFPA Standard: NFPA 99 Health Care Facilities Code (2012)** **11.3.2.6** Cylinder or container restraints shall comply with 11.6.2.3. **11.6.2.3** Cylinders shall be protected from damage by means of the following specific procedures: (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. **Special Precautions-Storage of Cylinders and Containers** **11.6.5.2** If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. **11.6.5.3** Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.
§ 51.210 (b) Disclosure of State agency and individual responsible for oversight of facility. 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 more than minimal harm **Residents Affected** – Many	Based on record review and interviews, the facility failed to notify the Office of Geriatrics and Extended Care (GEC), (Veterans Affairs) VA Headquarters of a change in Administrative Staff A and Administrative Nurse A. The findings include: During a review of the Administration and Fiscal process, the facility was unable to provide a letter notifying the Office of Geriatrics and Extended Care (GEC), VA Headquarters of the change in Administrative Staff A that was effective on [DATE], and the change in Administrative Nurse A, effective on [DATE]. During an interview, on 6/18/25, at 10:50 a.m., Administrative Staff A stated that they were unaware of the requirement to notify the GEC of the staff changes. Administrative Staff A contacted the VA GEC Manager, who confirmed that the GEC had not received a formal letter notifying the office of the changes in Administrative Staff A and Administrative Nurse A.