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: Illinois Veterans' Home at Chicago

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

Onsite / Virtual: Onsite

Dates of Survey: 5/3/2022 – 5/5/2022

NH / DOM / ADHC: NH

Survey Class: Recognition

Total Available Beds: 200

Census on First Day of Survey: 20

Deficiency	Findings
	Initial Comments: A VA Recognition survey was conducted from May 3, 2022, through May 5, 2022, at the Illinois Veterans' Home at Chicago. The survey revealed the facility was not in compliance with 38 CFR part 51 Federal Regulations for State Veterans Homes.
§51.200(a) Life safety from fire The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. (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	1. Based on observation and interview, the facility failed to maintain the two-hour fire resistance rating of three (3) of three (3) elevator shafts (elevator one (1), two (2), and three (3). The deficient practice affected 24 of 24 compartments, staff, and all residents. The facility has the capacity for 200 beds with a census of 20 on the day of survey. The findings include: Observations of the two-hour rated construction on the outside of the elevators one (1), Two (2), and three (3) shafts (located in the attic spaces above 1st, 2nd, 3rd,4th, & 5th floors) on 05/03/2022 between 2:49 p.m. and 3:30 p.m. revealed multiple metal pipes, conduits, and sprinkler piping which penetrated the barriers, all of which had unsealed openings measuring in various sizes and were not protected or filled with a material that was capable of maintaining the barrier's fire resistance. An interview at the time of observation with Maintenance Staff A confirmed that elevators one (1), two (2), and three (3) shafts

	(located in the attic spaces above 1st, 2nd, 3rd,4th, & 5th floors) two-hour rated construction had unsealed penetrations and were not protected or filled with a material that was capable of maintaining the barrier's fire resistance. Maintenance Staff A further indicated that they were unaware that the vertical shafts needed to be sealed and protected. Additionally, Maintenance Staff A said that they started last year and were not able to get to it due to the size of the building. In an interview on 05/05/2022 at 4:00 p.m. during the final exit, Maintenance Staff A stated that all the barriers had been properly sealed. The census of 20 was verified by Administrative Staff A on 05/03/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 05/05/2022 at 4:00 p.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.3 Protection.** **19.3.1 Protection of Vertical Openings**. Any vertical opening shall be enclosed or protected in accordance with Section 8.6, unless otherwise modified by 19.3.1.1 through 19.3.1.8. **8.6 Vertical Openings.** **8.6.1 Floor Smoke Barriers**. Every floor that separates stories in a building shall meet the following criteria: (1) It shall be constructed as a smoke barrier in accordance with Section 8.5. (2) It shall be permitted to have openings as described by 8.6.6, **8.6.7, 8.6.8, 8.6.9, or Chapters 11 through 43.** **8.6.2 Continuity**. Openings through floors shall be enclosed with fire barrier walls, shall be continuous from floor to floor, or floor to roof, and shall be protected as appropriate for the fire resistance rating of the barrier. **8.6.3 Continuity Exemptions**. The requirements of 8.6.2 shall not apply where otherwise permitted by any of the following: (1) Where penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, pneumatic tube conveyors, and similar items to accommodate electrical, mechanical, plumbing, and communications systems are protected in accordance with 8.3.5.1 and 8.5.6 **8.3.5.1Firestop Systems and Devices Required.** Penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration

	Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through- Penetration Firestops, at a minimum positive pressure differential of 0.01 in. water column (2.5 N/m2) between the exposed and the unexposed surface of the test assembly. 2. Based on observations and interview, the facility failed to maintain the smoke barriers. The deficient practice affected 24 of 24 compartments, staff, and all residents. The facility had the capacity for 200 beds with a census of 20 on the day of survey. The findings include: a. Observation during the building inspection tour on 05/04/2022 at 8:27 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors on the first (1st) floor by elevator one (1) revealed that six (6), three (3) inch conduits with bundles of cables passing through the barrier were unsealed, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA, 101 Life Safety Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of the unsealed penetrations. b. Observation during the building inspection tour on 05/04/2022 at 8:28 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors on the second floor by elevator one (1) revealed two (2) unsealed, one (1) inch conduits as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA, 101 Life Safety Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of the unsealed penetrations. c. Observation during the building inspection tour on 05/04/2022 at 8:37 a.m. of the smoke barrier above the lay-in ceiling tiles at the cross-corridor doors on the second (2nd) floor leading into house one (1) revealed two (2) unsealed penetrations, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of the unsealed penetrations. d. Observation during the building inspection tour on 05/04/2022 at 8:38 a.m. of the smoke barrier above the lay-in ceiling tile at the cross-corridor doors on 2nd floor leading into house 3 above the dining room revealed two unsealed, one (1) inch conduits, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA, 101 Life Safety Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of the unsealed penetrations.

	e. Observations during the building inspection tour on 05/04/2022 between 8:42 a.m. and 9:39 a.m. of the smoke barriers above the lay-in ceiling tiles at the cross-corridor doors on the 2nd, 3rd, 4th and 5th floors of Houses 1, 2, 3, and 4 revealed numerous unsealed sprinkler piping, cables, and metal piping penetrations in various locations of the barriers. Additionally, there were unsealed conduits of various sizes in the barriers, as prohibited by sections 19.3.7.3 and 8.5.6 of NFPA, 101 Life Safety Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of the unsealed penetrations. In an interview on 05/05/2022 at 4:00 p.m. during the final exit, Maintenance Staff A stated that all the barriers were properly sealed. The census of 20 was verified by Administrative Staff A on 05/03/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 05/05/2022 at 4:00 p.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.7.3** Any required smoke barrier shall be constructed in accordance with Section 8.5 and shall have a minimum 1⁄2-hour fire resistance rating, unless otherwise permitted by one of the following: (1) This requirement shall not apply where an atrium is used, and both of the following criteria also shall apply: (a) Smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with 8.6.7(1)(c). (b) Not less than two separate smoke compartments shall be provided on each floor. (2)*Smoke dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air-conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 has been provided for smoke compartments adjacent to the smoke barrier. **8.5 Smoke Barriers.** **8.5.6 Penetrations.** **8.5.6.1** The provisions of 8.5.6 shall govern the materials and methods of construction used to protect through-penetrations and membrane penetrations of smoke barriers**.** **8.5.6.2** Penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected

	by a system or material capable of restricting the transfer of smoke. **8.5.6.3** Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of 8.3.5 to limit the spread of fire for a time period equal to the fire resistance rating of the assembly and 8.5.6 to restrict the transfer of smoke, unless the requirements of 8.5.6.4 are met. **8.5.6.4** Where sprinklers penetrate a single membrane of a fire resistance–rated assembly in buildings equipped throughout with an approved automatic fire sprinkler system, noncombustible escutcheon plates shall be permitted, provided that the space around each sprinkler penetration does not exceed 1⁄2 in. (13 mm), measured between the edge of the membrane and the sprinkler. **8.5.6.5** Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be securely set in the smoke barrier, and the space between the item and the sleeve shall be filled with a material capable of restricting the transfer of smoke. **8.5.6.6** Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: (1) It shall be provided on either side of the smoke barrier. (2) It shall be designed for the specific purpose. 3. Based on observations and interview, the facility failed to ensure electrical equipment was installed in accordance with the code. The deficient practice affected five (5) of twenty-four compartments, staff, and no residents. The facility had the capacity for 200 beds with a census of 20 on the day of survey. The findings include: a. Observation on 05/04/2022 at 8:37 a.m. revealed a junction box located in the attic space adjacent to the smoke barrier on the second (2nd) floor in house one (1) was not protected with a cover, as prohibited by article 314.28 of NFPA 70, National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers. b. Observation on 05/04/2022 at 8:49 a.m. revealed a junction box located in the attic space adjacent to the smoke barrier on the 3rd floor in house one (1) was not protected with a cover, as prohibited by article 314.28 of NFPA 70, National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers.

c. Observation on 05/04/2022 at 8:49 a.m. revealed a junction box located in the attic space adjacent to the smoke barrier on the 3rd floor in house one (1) was not protected with a cover, as prohibited by article 314.28 of NFPA 70, National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers.

d. Observation on 05/04/2022 at 8:49 a.m. revealed a junction box located in the attic space adjacent to the smoke barrier on the 3rd floor in house four (4) was not protected with a cover, as prohibited by article 314.28 of NFPA 70, National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers.

e. Observation on 05/04/2022 at 9:04 a.m. revealed a junction box located in the attic space adjacent to the smoke barrier on the 3rd floor in house four (4) was not protected with a cover as prohibited by article 314.28 of NFPA 70 National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers.

f. Observation on 05/04/2022 at 9:08 a.m. revealed a junction box located in the attic space adjacent to the smoke barrier on the 4th floor in the central core near elevator one (1) was not protected with a cover as prohibited by article 314.28 of NFPA 70 National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers.

g. Observation on 05/04/2022 at 9:23 a.m. revealed two (2) junction boxes located in the attic space adjacent to the smoke barrier on the 4th floor in house four (4) were not protected with a cover as prohibited by article 314.28 of NFPA 70 National Electrical Code. An interview with Maintenance Staff A at that time revealed the facility was not aware of any junction boxes missing covers.

In an interview on 05/05/2022 at 4:00 p.m. during the final exit, Maintenance Staff A stated that all open junction boxes were properly covered.

The census of 20 was verified by Administrative Staff A on 05/03/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 05/05/2022 at 4:00 p.m.

Actual NFPA Standard: NFPA 101, Life Safety Code (2012)
19.5 Building Services.
19.5.1 Utilities.
19.5.1.1 Utilities shall comply with the provisions of Section 9.1.
9.1 Utilities.
9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service.
NFPA 70 National Electrical Code
314.28 Pull and Junction Boxes and Conduit Bodies.
Boxes and conduit bodies used as pull or junction boxes shall comply with 314.28(A) through (E).
(C) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110.

4. Based on observation and interview, the facility failed to maintain 15 second delayed egress doors. The deficient practice affected two (2) of twenty-four compartments, staff, and no residents. The facility had the capacity for 200 beds with a census of 20 on the day of survey.

The findings include:

a. Observation on 05/04/2022 at 11:26 a.m. revealed the delayed egress exit doors, located on the 5th floor inside house one (1), would not release when 15 pounds of force was applied to the panic bar hardware to initiate the irreversible process to release the lock on the exit doors. The doors would only release when 30 pounds of force was applied to the panic bar hardware when an accessibility pressure tool was used. An interview with Maintenance Staff A at that time revealed the facility was not aware of the doors requiring over 15 pounds of force to initiate the irreversible process to release the lock on the exit doors.

b. Observation on 05/04/2022 at 12:10 a.m. revealed the delayed egress exit doors, located on the 2nd floor inside house one (1), would not release when 15 pounds of force was applied to the panic bar hardware to initiate the irreversible process to release the lock on the exit doors. The doors would only release when 20 pounds of force was applied to the panic bar hardware when an accessibility pressure tool was used. An interview with Maintenance Staff A at that time revealed the facility was not aware of the doors requiring over 15 pounds of force

	to initiate the irreversible process to release the lock on the exit doors. In an interview on 05/05/2022 at 4:00 p.m. during the final exit, Maintenance Staff A stated that the delayed egress doors were adjusted. The census of 20 was verified by Administrative Staff A on 05/03/22. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 05/05/2022 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: (2) Delayed-egress locks complying with 7.2.1.6.1 shall be permitted ... **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: (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 lb (67 N).
§51.210(c)(7-11) Annual State Fire Marshall's Report (8) Annual certification from the responsible State Agency showing compliance with Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) (VA Form 10-0143A, which is available at any VA medical center and at http://www.va.gov/vaforms); (9) Annual certification for Drug-Free Workplace Act of 1988 (VA Form 10-0143, which is available at any VA medical center and at http://www.va.gov/vaforms); (10) Annual certification regarding lobbying in compliance with Public Law	Based on record review and interview, the facility failed to obtain an Annual State Fire Marshall's report. The deficient practice affected 24 of 24 compartments, staff, and all residents. The facility had the capacity for 200 beds with a census of 20 on the day of survey. The findings include: Records review on 05/03/22 at 9:57 a.m. revealed there was not documentation to indicate that the facility had an inspection by the State Fire Marshall or had obtained an inspection report from the State Fire Marshall, as required by section 51.210 (7). During an interview on 05/03/22 at 11:30 a.m. with Maintenance Staff A, they said that they were unaware that the facility was to have the building inspected by the State Fire Marshall. They went on to say that they were going to schedule the inspection.

101-121 (VA Form 10-0144, which is available at any VA medical center and at http://www.va.gov/vaforms); and (11) Annual certification of compliance with Title VI of the Civil Rights Act of 1964 as incorporated in Title 38 CFR 18.1-18.3 (VA Form 10-0144A, which is available at any VA medical center and at http://www.va.gov/vaforms). Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Many	The census of 20 was verified by Administrative Staff A on 05/03/2022. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the exit interview on 05/05/2022 at 4:30 pm.
§51.210(h) Use of outside resources (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility management must have that service furnished to residents by a person or agency outside the facility under a written agreement described in paragraph (h)(2) of this section. (2) Agreements pertaining to services furnished by outside resources must specify in writing that the facility management assumes responsibility for— (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. (3) If a veteran requires health care that the State home is not required to provide under this part, the State home may assist the veteran in obtaining that care from sources outside the State home, including the Veterans Health Administration. If VA is contacted about providing such care, VA will determine the best option for obtaining the needed services and will notify the veteran or the authorized representative of the veteran.	Based on observation, interview, record review, and review of facility contracts for service, it was determined that the facility failed to ensure dental services were available and provided in-house by an employed, qualified professional dentist and/or under a written agreement to obtain dental services from an outside resource. One (1) of eight (8) sampled residents (Resident #5) had an appointment to receive routine dental services at the local Veteran's Administration Medical Center (VAMC). There was no written agreement in place that specified the facility management assumed responsibility for obtaining dental services that met professional standards and principles. The findings include: A review of facility contracts and/or written agreements revealed a document titled, "Request for Quote," dated 12/7/21, that specified the facility was seeking quotes from a qualified vendor to provide Dental and Hygienist Services at the facility. The document specified "Quotes must be returned by 8/1/2021, 12:00 a.m." The vendor's name identified on the document was "[VENDOR]." The agreement document specified the provider would offer mobile dental services at the facility and provide full dental care services for residents. The document had not been signed, indicating an agreement for dental services had not been obtained from the dental provider. Continued review of facility contracts/written agreements revealed no additional documents regarding the provision of dental services to residents were provided. Resident #5 was admitted to the facility in 2022. A review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated independence in cognitive skills for

Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected - Few	daily decision making. The MDS identified no concerns related to lost or broken teeth/dentures and no mouth ulcers or pain. A review of Resident #5's Physician Order revealed on [DATE] an order was given for the resident to be seen for a dental appointment at the VAMC on [DATE] for a one time only dental appointment. In an interview with Resident #5 on 5/5/22 at 4:00 p.m., they stated that they received a regular diet and didn't have any problems chewing the food. They stated that they periodically had problems with their teeth, on and off, for the past few years. The resident stated that they were glad they had a dental appointment, and that June would be here before you knew it. An interview was conducted on 5/5/22 at 3:25 p.m. with Administrative Staff A. Administrative Staff A acknowledged the facility did not have a written agreement with the local VAMC, or local Dental Providers in the area, for the provision of dental services for residents. Administrative Staff A stated that the facility was in the process of reaching out to local Dental Providers to secure an agreement for dental services. Administrative Staff A stated that they were not aware of a requirement for a written agreement with the VAMC for dental services if residents received services there. Administrative Staff A stated that they participated in "daily huddles" with clinical staff to discuss resident care and services. They did remember at one of those huddles, Resident #5 was discussed regarding the resident requesting dental services, and an appointment had been made. Administrative Staff A stated that outside dental services would be paid for by the resident and/or responsible party. An interview was conducted on 5/5/22 at 3:28 p.m. with Administrative Nurse A. They confirmed the "Request for Quote" document, dated 12/7/21, had not been signed and no dental services agreement was in effect. Administrative Staff A stated that when they realized the facility did not provide dental services for the residents, they had prepared the "Request for Quote" document and submitted it to "legal" for approval. Administrative Nurse A stated that they did not want the residents going without dental services and was continuing to work with the administration toward securing in-house dental services. Administrative Nurse A stated that Resident #5 had not complained of mouth/dental pain, and they were not sure why the outside dental appointment was made for the resident. According to Administrative Nurse A, a lot of newly admitted residents had come in having already scheduled dental appointments with outside resources. The facility worked with each resident to ensure that they had transportation to outside scheduled appointments. If the appointment was far away from

	the facility, the facility made dental services appointments for the residents at locations that were closer to the facility. An interview was conducted on 5/5/22 at 3:40 p.m. with Licensed Nurse A. They stated that the dental appointment for Resident #5 was a routine checkup and that the resident never complained of teeth or mouth pain. An interview was conducted on 5/5/22 at 3:45 p.m. with Certified Nurse Aide A. They stated that Resident #5 never complained about mouth pain.