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 – LaSalle

Location: 1015 O'Conor Ave., LaSalle, IL 61301

Onsite / Virtual: Onsite

Dates of Survey: 9/9/24 – 9/12/24

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 190

Census on First Day of Survey: 85

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from September 9, 2024, through September 12, 2024, at the Illinois Veterans' Home – LaSalle. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.40 (a) Basic rate. Except as provided in §51.41, VA will pay per diem for care provided to an eligible veteran at a State home at the lesser of the following rates: (1) One-half of the daily cost of the care for each day the veteran is in the State home, as calculated under paragraph (b) of this section. (2) The basic per diem rate for each day the veteran is in the State home. The basic per diem rate is established by VA for each fiscal year in accordance with 38 U.S.C. 1741(a) and (c). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The facility was unable to demonstrate that the correct basic rate of per diem was paid for care provided to an eligible Resident at a State home. The findings include: Based on communication and record reviews, it was identified the facility computes their daily cost of care on an annual basis. The facility failed to provide the calculated actual direct and indirect cost for each month from September 2023 to August 2024. Facility leadership was unable to validate whether the basic rate of per diem was calculated and subsequently paid correctly.

§ 51.41 (c) (2) Payments under State home care agreements. (2) The State home shall not charge any individual, insurer, or entity (other than VA) for the nursing home care paid for by VA under a State home care agreement. Also, as a condition of receiving payments under paragraph (c), the State home must agree not to accept drugs and medicines from VA provided under 38 U.S.C. 1712(d) on behalf of veterans covered by this section and corresponding VA regulations (payment under this paragraph (c) includes payment for drugs and medicines). **Level of Harm** – No Actual Harm, with potential for minimal harm **Residents Affected** – Many	The facility was unable to demonstrate that no individual, insurer, or entity was charged for the nursing home care paid for by VA under a VA provider agreement for services rendered by community providers for prevailing rate Veterans. The findings include: Based on communications and record reviews, it was identified that the facility utilizes third-party providers for podiatry, laboratory, radiology and other diagnostic services, and mental health services. Upon review of the written agreements and invoices between the facility and the third-party providers, it was identified that insurance was billed for services for Residents for whom the facility receives the prevailing rate of VA Per Diem for nursing home care. 1. Podiatry services: The third-party vendor billed prevailing rate Residents insurance from 9/2023 to 8/2024. The contract was amended 8/20/2024 instructing the vendor to bill the facility. 2. Laboratory and Radiology and other diagnostic services: The third-party vendor billed prevailing rate Residents insurance from 9/2023 to 7/2024. The facility notified their vendor in July 2024 to start billing the facility. 3. Mental Health services: The third-party vendor billed prevailing rate Residents insurance from 9/2023 to 7/2024. The contract was amended 8/5/2024 instructing the vendor to bill the facility. The facility leadership could not provide evidence to demonstrate that the facility had paid the costs for Prevailing Rate Veterans in receipt of podiatry, laboratory, radiology and other diagnostic services, and mental health services and no individual, insurer, or entity was charged for nursing home care.
§ 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 review of facility policies, the facility failed to ensure that food was prepared under sanitary conditions to decrease the risk of contamination and food borne illnesses. Specifically, 1) the facility failed to ensure the sanitization buckets had the proper level of sanitizer as required for two (2) of three (3) sanitation buckets observed in the [LOCATION], and 2) the facility failed to properly train the dietary staff to read or report the temperature gauge accurately for one (1) of one (1) walk-in freezer. The findings include: A review of the facility's policy titled, "Sanitizer Concentration Log," dated 6/1/23, revealed: "The Dietary department will test

	the sanitizer concentration level daily and record the results to ensure accordance with IDPH [Illinois Department of Public Health] regulations regarding proper sanitizing during the dishware washing process." A review of the facility's guidelines provided as an undated policy and set forth by the Illinois Department of Public Health titled, "Food Safety," revealed: "The food industry is responsible for producing safe food. IDPH and local food protection programs are responsible for setting food standards, conducting inspections, and monitoring food products. Illinois public health officials monitor the state's food supply at various steps in the food chain to assure food stays safe." No other information was included on this document related to sanitization or temperature logs for refrigerators or walk-in freezers. 1. During an observation, on 9/9/24, at 11:33 a.m., Dietary Staff A tested three (3) sanitization buckets that were prepared and ready for use. The tests for two (2) of three (3) sanitation buckets read zero (0) parts per million (ppm) of a sanitization solution present. The buckets were used to clean and sanitize areas where raw and uncooked foods were being prepared, which could lead to food borne hazards. During an interview, on 9/9/24, at 11:33 a.m., with Dietary Staff A, who performed the testing observed, they confirmed that two (2) of the three (3) buckets tested read zero (0) ppm. They stated that staff should maintain the sanitizer buckets solution at or above 200 ppm to effectively reduce the risk of food borne illnesses. They stated the buckets they tested had been emptied and refilled with proper solution within the past 45 minutes. They further confirmed that staff had been utilizing these surfaces where the buckets were located, and the buckets were used throughout their meal preparation in all three (3) areas where the buckets were placed. During an interview, on 9/9/24, at 11:45 a.m., Dietary Staff B stated they were never made aware there was a problem with proper sanitation measuring outside of the expected range of 200 ppm or greater. They stated there was no current quality assurance monitoring in place to ensure the sanitation was being properly measured. Dietary Staff B stated their concerns were maintaining a safe and sanitary environment throughout all the [LOCATION] preparation surface areas. Dietary Staff B stated their additional concerns were the risk of food borne illnesses developing because the surfaces were used to prepare uncooked and raw foods and were not properly sanitized. Additionally, they stated that the policy was changed during the previous pandemic of Covid-19, but had not been updated to include the proper sanitation range at which the sanitation buckets should be kept. Dietary Staff B stated the ppm range

	was not listed on the current policy, but said the staff knew that the measuring strips should change colors and match the indicator on the package test strips to read at 200 ppm or greater for proper, effective sanitation. During an Interview, on 9/10/24, at 10:00 a.m., Dietary Staff C stated they were never made aware there was serious concern regarding the lack of sanitation solution levels being maintained in the buckets used to wipe down food preparation areas throughout the [LOCATION]. Their concern also included the "lack of unsanitary environment in the food preparation areas," and recognized this could increase the risk of contaminated food being served to the residents. 2. A review of the facility policy titled, "Food Storage Standards," dated 10/18/23, revealed: "All employees will adhere to the food storage standards established by Illinois Veterans Home (LVH) -LaSalle, in accordance with the Illinois Department Public Health and Food Code guidelines to ensure the overall quality and safety of all food serve to its residents...Procedure: Section (§) one (1) a. Criteria for Freezer Storage all freezer units will maintain a temperature of ten (-10) degrees Fahrenheit (°F) to zero (0) °F which will be recorded on the temperature log each shift daily (AM = 5a-1p; PM = 11a-7pm.)" Further review of the food safety document presented by Dietary Staff C as their freezer guideline revealed: "the ideal temperature for a walk-in freezer is between negative ten (-10) °F to zero (0) °F or -23 to -18 degrees Celsius (°C). This ensures that food stays frozen and safe for consumption." A review of the electronic temperature display logs for the dates of 6/17/24, through 8/26/24, revealed a positive deflective graph indicating temperature ranges from five (5) °F to 55 °F. The graph indicated there was never a temperature during this time that was lower than 10 °F, and often showed temperature spikes reaching greater than 50 °F. An observation, on 9/9/24, at 11:15 a.m., revealed the exterior temperature for the walk-in freezer read 15 °F, and the interior temperature gauge read 15 °F. An observation, on 9/10/24, at 9:37 a.m., was conducted by the surveyor of six (6) [LOCATION] staff attempting to read the external gauge of the walk-in freezer, and each reported their findings to the surveyor. The readings by Dietary Staff C were 15 °F; Dietary Staff B, Dietary Staff D, Dietary Staff E, and Dietary Staff F reported readings of 14 °F; and Dietary Staff G reported readings of 18 °F. Based on this observation, the staff

	were reading the temperatures in °C on the gauge, but documenting them in °F. An interview, on 9/10/24, at 9:37 a.m., with Dietary Staff B and Dietary Staff C, Dietary Staff D, Dietary Staff E, Dietary Staff F, and Dietary Staff G, who all worked on 9/10/24, revealed that each stated they were unaware of the different measurements of °F and °C on the external freezer thermometer gauge, but each stated when reading the gauge at the specific number they saw, they documented the temperature to be a negative (-15) °F to match the expected temperature range listed on the temperature log sheet. Each member of the staff further stated they had never received any education on the proper way to read the gauge, and stated the log sheet indicated the range was to be negative ten (-10) and zero (0), so they each documented a negative number. During an interview, on 9/10/24, at 9:50 a.m., Dietary Staff B stated they did not know the difference in the two readings on the exterior and interior thermometers; therefore, they had not provided any education to the staff on the proper way to read the two (2) temperatures (°F and °C) displayed on the external thermometer. During an Interview, on 9/10/24, at 10:00 a.m., Dietary Staff C stated they were not aware of the difference in °F and °C temperature readings. They stated no one had ever explained the difference in the two forms of measurements. They stated the facility used the Illinois Department Public Health (IDPH) and the State Dietary Code as their resources for proper temperature of the freezer; therefore, the temperature logs sheets were designed following those recommendations. They stated the expected range set forth by the facility's guidelines was to maintain the temperature between negative ten (-10 °F) and zero (0 °F). They further stated they had not been performing routine temperature log audits, but stated it was a good idea. An interview, on 9/10/24, at 3:15 p.m., with Maintenance Staff A revealed they were aware that the facility utilized an electronic temperature monitoring system, which tracked the internal temperatures of the freezer in the [LOCATION]. They stated the electronic monitoring system was not equipped with a mechanism to alarm staff when the set parameters reached greater than 20°F, which is where the company who installed the system had set as the out-of-range parameter when it was initially installed. They stated the maintenance department depended on the dietary staff to alert them if the temperature reading was out of the normal range. They stated the maintenance department did not have a policy or procedure for when maintenance staff should check for accuracy of the

	freezer thermometer, or when it needed to be calibrated. They stated the maintenance department had not received any notification from the dietary department to indicate the temperature reading was outside the set range of 20 °F. They stated the electronic system documented a continuous running temperature, and was set to a high parameter of 20 °F, and they were not aware what the normal range was to be set to maintain compliance. An interview, on 9/12/24, at 10:40 a.m., with both Administrative Staff A and Administrative Nurse A revealed their expectations of the Dietary department included preparing and storing food in a safe and sanitary condition to eliminate the risk of food contamination and food related illnesses.
§ 51.190 (b) Preventing spread of infection. (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on observations, interviews, and facility policy review, the facility failed to follow the facility's infection control protocol to prevent potential cross-contamination when staff entered a resident's room who was on Enhanced Barrier Precautions (EBP) and when staff did not don all required personal protective equipment (PPE) during a wound care observation. This failure affected one (1) of one (1) sampled resident (Resident #3). The findings include: Review of a facility policy titled, "Standard and Transmission-Based Precautions," revised 3/19/24, documented the following: "V. Enhanced Barrier Precautions - Use Enhanced Barrier Precautions with a resident known to be infected or colonized with a targeted multidrug-resistant organism (MRDO). High-contact resident care activities have been shown to provide opportunities for transfer of MDROs to staff hands and clothing. Enhanced Barrier Precautions fall on the spectrum between Standard Precautions and Contact Precautions. They are more specific than Standard Precautions as they require PPE uses for high-contact resident-care activities. They are less restrictive than Contact Precautions as PPE is not required for every room entry/activity, residents are not restricted to their rooms, and placement in a private room is not required… D. Wear gown and gloves when performing high-contact resident care activities, 1. High-contact care activities include assisting with transferring, bathing, dressing, toileting, changing linens, care for wounds or indwelling devices, and providing hygiene such as brushing teeth or hair."

	Review of the CDC Enhanced Barrier Precaution sign that appeared on Resident #3's door revealed: "EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound Care: any skin opening requiring a dressing" During a wound care observation, on 9/10/24, for Resident #3 at 9:05 a.m., Licensed Nurse A entered the resident's room, washed their hands, and applied gloves, but did not don a gown. During an interview, on 9/10/24, at 9:45 a.m., Licensed Nurse A confirmed they should have donned a gown before entering the resident's room, per the Enhanced Barrier Precautions (EBP) protocol. During an interview, on 9/10/24, at 9:50 a.m., Administrative Nurse A confirmed all nursing staff should don a gown and gloves when they provided wound care, per the EBP protocol. During an interview, on 9/10/24, at 1:00 p.m., Licensed Nurse B confirmed wound care for a resident on EBP would require a gown and gloves because of high contact with the resident.
§ 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	**<u>Fire Safety and Operations</u>** 1. Based on observation, record review, and interview, the facility failed to document the inspection and testing of the required fire doors installed throughout the facility. The deficient practice affected 13 of 13 smoke compartments, staff, and all residents. The facility had a capacity for 190 beds with a census of 85 on the first day of the survey. The findings include:

Residents Affected – Many	Observation during the building inspection tour, on 9/9/24, from 11:50 a.m., to 2:15 p.m., revealed there were 15 fire doors in the facility. Record review, on 9/10/24, at 9:25 a.m., revealed there was no documentation available to indicate that the required fire doors were inspected and tested annually, as required by section 5.2.1 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. An interview, on 9/10/24, at 10:57 a.m., with Maintenance Staff A revealed there was no documentation the fire doors had been tested because the previous Maintenance Staff A informed the staff that the test did not have to be performed. The census of 85 was verified by Administrative Staff A on 9/9/24, at 10:00 a.m. The findings were acknowledged by Maintenance Staff A and verified by Administrative Staff A during the exit interview on 9/10/24, at 11:05 a.m. **Actual NFPA Standard: NFPA 101 Life Safety Code (2012)** **19.7.6 Maintenance and Testing.** See 4.6.12. **4.6.12 Maintenance, Inspection, and Testing.** **4.6.12.1** Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or other feature shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. **8.3.3 Fire Doors and Windows.** **8.3.3.1** Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. **Actual NFPA Standard: NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010)** **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. **(2)** Glazing, vision light frames, and glazing beads are intact; and securely fastened in place, if so equipped. **(3)** The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. **(4)** No parts are missing or broken. **(5)** Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. **(6)** The self-closing device is operational; that is, the active door completely closes when operated from the full open position. **(7)** If a coordinator is installed, the inactive leaf closes before the active leaf. **(8)** Latching hardware operates and secures the door when it is in the closed position. **(9)** Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. **(10)** No field modifications to the door assembly have been performed that void the label. **(11)** Gasketing and edge seals, where required, are inspected to verify their presence and integrity.