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 - Manteno

Location: One Veterans Drive, Manteno, IL 60905

Onsite / Virtual: Onsite

Dates of Survey: 10/18/22 through 10/21/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 304

Census on First Day of Survey: 167

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from October 18, 2022, through October 21, 2022, at the Illinois Veterans Home - Manteno. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.43(b) Drugs and medicines for certain veterans VA will also furnish drugs and medicines to a State home for a veteran receiving nursing home, domiciliary, or adult day health care in a State home pursuant to 38 U.S.C. 1712(d), as implemented by §17.96 of this chapter, subject to the limitation in §51.41(c)(2). **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	The facility was unable to demonstrate they received only drugs and medicines for Residents who were eligible to receive such medications. Based on interviews and record review, when Residents were seen at the VA of jurisdiction for specialty care fill prescriptions prior to returning to the State home at the VA Pharmacy, the facility reported that when medications were received, they were accepted, process followed to enter orders, and put in use for that Resident. The facility was not validating the Resident's eligibility when receiving medications in this manner. In an interview with Administrative Staff A and Consultant Staff A, it was identified that the facility failed to establish a mechanism to ensure only eligible Residents received medications from the VA of jurisdiction. The facility reported they identified this issue during review of the medication checklist and were changing their process. The facility did not reimburse the VA of jurisdiction for these medications.

§ 51.120 (i) Accidents. The facility management must ensure that— (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	Based on record reviews and interviews the facility failed to ensure that the residents' environment remained free of potential accident hazards. Specifically, the facility failed to complete a smoking assessment for one (1) of 11 residents that smoked in the facility (Resident #17). The findings include: Review of the facility's Policy and Procedure titled, "Smoking Evaluation-Resident," last reviewed 9/22, revealed: "Policy: A Smoking Evaluation UDA will be completed on all residents who smoke to evaluate resident's safety. Personnel: [Licensed Nurses] Procedure: 1. A Resident Smoking Evaluation will be completed on all residents who smoke at the time of admission, quarterly/annually and if a significant change in condition occurs that would affect the resident's ability to safely handle smoking materials. 2. Nurses completing the initial evaluation can make an Interdisciplinary team decision for immediate resident safety. Decision will then be reviewed and updated at time of care plan meeting. 3. Interdisciplinary Team Decision is made after review of information is provided. Rationale should be documented to support decision made. 4. Any additional comments can be written as a Progress Note in the Electronic Health Record. 5. And resident who smokes shall have the information addressed in their care plan and communicated to all direct staff if indicated. Care plan information includes: independent vs. supervision with smoking and if resident desires smoking cessation. 6. Resident smoking rules will be reviewed with the resident upon admission and as needed. The resident will then sign [they] understand[~~s~~] the rules as described." Review of Resident #17 records revealed that the resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to: Chronic Obstructive Pulmonary Disease (COPD) (unspecified), Localized Edema, Bipolar Disorder (unspecified), Essential (primary) Hypertension, shortness of breath, and dependence on supplemental oxygen. Review of Resident #17 records also revealed that there were never any smoking assessments done. The Care Plan stated that:

	"[Resident #17] smokes despite having COPD and being oxygen (O2) dependent. [They] understand[s] the risks involved, such as increasing exacerbations of COPD, secondary complications, and especially possibility of O2 ignition. [DATE] [Resident #17] will remain educated in the risks of smoking, COPD, and O2 use. Date initiated: [DATE] Revision on: [DATE] Target date: [DATE] [Resident #17] will remain safe when [they] decide[s] to engage in smoking. [They] will demonstrate proper safety precautions at all times when smoking. Date initiate: [DATE] Revision: [DATE] Target Date: [DATE] Member will report any unusual circumstances (physical, environmental, mechanical) immediately that occur when [they] decide[s] to engage in smoking. [DATE] Member will show proper safety technique regarding use of O2 around sources of ignition such as lighters, cigarettes, motorized w/c." A review of the Resident's previous Minimum Data Sets (MDS), dated [DATE], (Annual), [DATE], (Quarterly), and [DATE], (Quarterly), revealed that Resident #17 was assessed in Section J1300 for "Current Tobacco Use" and marked "Yes" for all three assessments. An interview was conducted, on 10/19/22, at 1:58 p.m., with Resident #17. When asked whether or not they were a smoker, they stated that they were a smoker but hadn't smoked since moving to the current unit [LOCATION], which was several weeks ago according to their recollection. The resident mentioned that their cigarette use had cut down a lot and only happened when there was a craving for it. They said that the risks were understood related to smoking due to their medical condition, and that there currently were not any smoking materials in their possession. There was also mention that during their stay in [LOCATION], they did have a cigarette or two (2) and smoked them outside. They were fairly independent and would occasionally get a pass to take the city bus and go to the store or on any other errands necessary. An interview was conducted, on 10/20/22, at 2:49 p.m., with Administrative Nurse A. They stated that they never witnessed Resident #17 smoking. Administrative Nurse A mentioned that they took over the Administrative Nurse job for unit [LOCATION] two years ago. They said that since the previous Administrative Nurse had indicated that the resident was a smoker, they just added it as well. Administrative Nurse A mentioned that Administrative Nurse B was responsible for doing the smoking assessment for residents that resided on their unit. An interview was conducted, on 10/20/22, at 3:00 p.m., with Licensed Nurse A. They mentioned that the resident should have

	had a smoking assessment completed once it was recognized that they had been smoking. An interview was conducted, on 10/20/22, at 3:14 p.m., with Administrative Nurse C. An inquiry was made regarding the expectations when a resident was identified as a smoker but was not considered a smoker upon admission. They stated that upon notification of being a smoker, the charge nurse on the unit was responsible for doing the smoking assessment. Smoking Care Plans were updated quarterly, as well. Administrative Nurse C mentioned that they were told that Resident #17 didn't smoke, and Resident #17 also said that they didn't smoke. When it was identified/observed by staff that the resident was a smoker, an assessment should have been done. Administrative Nurse C also stated that during the time that Resident #17 was observed smoking, they said that they had gotten the cigarette from another resident and that they would not do it again.
§ 51.120 (l) Special needs. The facility management must ensure that residents receive proper treatment and care for the following special services: (1) Injections; (2) Parenteral and enteral fluids; (3) Colostomy, ureterostomy, or ileostomy care; (4) Tracheostomy care; (5) Tracheal suctioning; (6) Respiratory care; (7) Foot care; and (8) Prostheses. **Level of Harm –** No Actual Harm, with potential for more than minimal harm **Residents Affected –** Few	Based on observations, interviews, and record review, the facility failed to ensure residents received respiratory services as ordered by the physician for one (1) of one (1) sampled resident reviewed for respiratory care (Resident #15). Specifically, the facility failed to ensure Resident #15 received oxygen according to Physician Orders. The findings include: Review of the facility's policy, "Respiratory Therapy," was provided on 10/21/22, and had an effective date of 4/14, and was last revised 9/22. The policy stated in pertinent part: "Policy: Oxygen therapy is administered to meet the metabolic demands of the body. Oxygen is to be given on order of the physician or 'standing order' policy by all [Licensed Nurses]Respiratory. Procedure: 1) An Oxygen order that is written by the Physician should include the following information: …b. Liter flow or FIO2 concentration… 4) As you apply Oxygen appliance to member's face, explain oxygen therapy and allow for member questions; Regulate the flow of oxygen as ordered." Resident #25, admitted [DATE], had diagnoses that included: Alzheimer's, Anxiety, Other Nonthrombocytopenic Purpura, Dementia, Mood Disturbance, Osteoporosis, and Parkinson's. They were on Hospice services.

	Record review revealed a [DATE], Physician Order for oxygen at 3-4 liters per minute (LPM) via nasal cannula every shift. A Care Plan, last revised on [DATE], documented the resident was at risk for pain related to degenerative joint disease, osteoporosis, myoclonus, and terminal prognosis of Parkinson's disease with end stage congestion. Interventions, in pertinent part, included oxygen 3L (liters) - 4L nasal canula continuous. Record review for Resident #15 revealed that from [DATE], to [DATE], the resident was documented to be on room air for 18 shifts. On 10/18/22, at 11:30 a.m., Resident #15 was observed in the common day room in a Broda chair. They were using their portable oxygen tank set at 2 LPM. They were again observed at 2:57 p.m., in the same room with their oxygen at the same setting. On 10/19/22, at 9:45 a.m., Resident #15 was observed in the common day room in a Broda chair. They were using their portable oxygen tank set at 2.5 LPM. Their bedroom oxygen concentrator was observed to be on at 2 LPM, but not in use. On 10/21/22, at 10:18 a.m., Resident #15 was observed in the common day room in a Broda chair. They were using their portable oxygen tank set at 3 LPM. On 10/21/22, at 10:18 a.m., Certified Nurse Aide A was interviewed. They said that the Certified Nurse Aides would monitor and document the oxygen saturations every shift for residents receiving oxygen. They said the Certified Nurse Aides would not adjust the LPM levels on the oxygen concentrators. Certified Nurse Aide A said Resident #15 used their portable oxygen when in the common room, and their portable concentrator when they were in bed. On 10/21/22, at 10:25 a.m., Administrative Nurse D was interviewed. They said oxygen was ordered by the physician. They said the Certified Nurse Aides would check oxygen saturations at least once a day and as needed. They said the nurses would chart in the resident records if a resident was on room air or on oxygen. Administrative Nurse D said that if a resident needed an adjustment to their oxygen usage, the nurse would call the physician. They said the nurse was ultimately responsible for making sure the LPM were set correctly. They said Resident #15 had a Physician Order for continuous oxygen use. They said the resident records should be audited every night for new Physician Orders. On 10/21/22, at 11:30 a.m., Administrative Staff A was interviewed. They said oxygen was a medication ordered by the physician.

	They said a nurse should put the oxygen on the resident, monitor the LPMs, monitor the oxygen saturations, and update the physician as needed. Administrative Staff A said the Certified Nurse Aides could measure the residents' oxygen saturation levels, but because oxygen was a medication, the nurse should be the one (1) to administer the medication and adjust the LPMs.
§ 51.190 (a) Infection control program. The facility management must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection control program. The facility management must establish an infection control program under which it— (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. **Level of Harm –** No Actual Haram, with potential for more than minimal harm **Residents Affected –** Many	Based on observations, interviews, and record review the facility failed to ensure that the infection control program was being followed upon entrance to the facility on three (3) out of four (4) days of the survey. A review of the policy section titled, "Infection Prevention," with the subject of "Health Screening for Staff," revised on 8/22, showed: "Purpose: To protect all staff and residents, IVHM [Illinois Veteran Home of Maneno] will perform health screenings of all staff prior to starting their shift and before any patient contact. The health screening includes the health assessments questions and a temperature. Temperatures will be recorded daily, or as directed by IDPH [Illinois Department of Public Health], CDC guidelines. Procedure: All staff on premises will report to their work area to be screened for fever/symptoms upon arrival to their shift (before patient care) daily." A review of the facility's "Visitor Screening Tool for COVID-19," showed that questions included: "1. Do you have any of the following signs and symptoms of COVID-19? [included was a list of signs and symptoms]. 2. Have you had a positive viral test for SARS-COV-2 in the last 10 days? Have you been exposed to a positive case of COVID-19 recently? If so, when? _____(date of last exposure)." Upon daily entrance into the facility, on 10/18/22, through 10/20/22, staff escorted the survey team to the conference room without checking for temperatures or asking health screening questions. During an interview, on 10/20/22, at 3:43 p.m., Licensed Nurse B stated the facility was currently in outbreak status. Licensed Nurse B stated that the facility had not been out of outbreak status since April, 2022. Licensed Nurse B also stated that the survey team should have been screened upon entrance to the facility on 10/18/22, 10/19/22, and 10/20/22.
§ 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.	**Smoke Barriers and Sprinklers** 1. Based on observation and interview, the facility failed to install Alcohol Based Hand Rub (ABHR) dispensers in accordance with the code. The deficient practice affected one (1) of seven (7) smoke compartments in [LOCATION], staff, and no residents. The

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Some	facility had a capacity for 304 beds with a census of 167 on the day of the survey. The findings include: Observation during the building inspection tour, on 10/19/22, at 3:21 p.m., of the [LOCATION] revealed a ABHR dispenser installed directly above a light switch, as prohibited by section 19.3.2.6 (8) of NFPA 101, Life Safety Code. An interview at that time with Maintenance Staff A revealed the facility was not aware the dispenser was installed above the light switch. The census of 167 was verified by Administrative Staff A on 10/18/22. The findings were acknowledged and verified by Administrative Staff A and Maintenance Staff A during the exit interview on 10/20/22. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.3.2.6*** Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met: (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source. **Electrical Systems** 2. Based on record review, observation, and interview, the facility failed to prohibit the use of power strips as a substitute for the fixed wiring. The deficient practice affected three (3) of seven (7) smoke compartments, staff, and 30 residents. The facility had a capacity for 304 beds with a census of 167 on the day of the survey. The findings include: Observation during the building inspection tour, on 10/19/22, at 11:59 a.m., revealed a power strip was used in the [LOCATION] to power a refrigerator, as prohibited by section 400.8 of NFPA 70 National Electric Code. An interview at the time revealed Maintenance Staff A was aware that power strips were not allowed as a substitute for fixed wiring, but was unaware that [LOCATION] staff were using power strips. Observation during the building inspection tour of [LOCATION], on 10/20/22, at 9:18 a.m., revealed a power strip in use to power a microwave in the [LOCATION], as prohibited by Article 400.8 of

	NFPA 70, National Electric Code. Record review at the time of the caution label behind the microwave indicated “Plug into a separate 15 AMP 120 Volt AC outlet only.” An interview, on 10/20/22, at 9:18 a.m., with Maintenance Staff A revealed the facility was not aware that Consultant Staff B was using a power strip. Observation during the building inspection tour of [LOCATION], on 10/20/22, at 9:54 a.m., revealed a power strip in use to power a microwave and mini refrigerator in [LOCATION], as prohibited by Article 400.8 of NFPA 70, National Electric Code. An interview at the time with Maintenance Staff A revealed the facility was not aware that Consultant Staff B was using a power strip. The census of 167 was verified by Administrative Staff A on 10/18/22. The findings were acknowledged and verified by Administrative Staff A and Maintenance Staff A during the exit interview on 10/20/22. **Actual NFPA Standard: NFPA 70 National Electrical Code (2011)** **400.8 Uses Not Permitted.** Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces *Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B)* (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this *Code* (7) Where subject to physical damage. 3. Based on observation and interview, the facility failed to properly segregate oxygen storage. The deficient practice affected one (1) of seven (7) smoke compartments in [LOCATION], staff, and no residents. The facility had a capacity for 304 beds with a census of 167 on the day of the survey. Observation during the building inspection tour, on 10/20/22, at 11:59 a.m., revealed that in the [LOCATION], located in [LOCATION] near room [LOCATION], empty and full cylinders were not segregated, as required by section 11.6.5.3 of NFPA 99, Health Care Facilities Code. During an interview at the time,

	Maintenance Staff A stated they were unaware the cylinders were not segregated. The census of 167 was verified by Administrative Staff A on 10/18/22. The findings were acknowledged and verified by Administrative Staff A and Maintenance Staff A during the exit interview on 10/20/22. **Actual NFPA Standard**: **NFPA 99, Health Care Facilities Code, (2012)**11.6.5 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