Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Illinois Veterans' Home – Anna

Location: 792 N. Main St, Anna, IL 62906

Onsite / Virtual: Onsite

Dates of Survey: 8/26/25 – 8/28/25

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 50

Census on First Day of Survey: 42

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from August 26, 2025, through August 28, 2025, at the Illinois Veterans' Home – Anna. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.70 (b) 9 – (i) Notification of changes. (i) Facility management must immediately inform the resident; consult with the primary physician; and if known, notify the resident's legal representative or an interested family member when there is— (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue	Based on interview, record review, and policy review, the facility failed to immediately consult the primary physician when there was an accident involving the resident which resulted in injury and had the potential for requiring physician intervention for one (1) of 22 sampled residents (Resident #5). The findings include: Review of Resident #5's clinical record revealed the resident was admitted on [DATE], with diagnoses that included Chronic Atrial Fibrillation and Diabetes. Resident #5's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview of Mental Status (BIMS) score of seven (7), which indicated severe cognitive impairment. Review of Resident #5's [DATE] Medication Administration Record (MAR) revealed the resident was prescribed Apixaban (a blood thinner) 5 mg twice daily for Atrial Fibrillation.

an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §51.80(a) of this part. **Level of Harm** – Actual Harm that is not immediate jeopardy **Residents Affected** – Few	A Communication with Physician progress note, dated [DATE], at 12:50 a.m., revealed that Resident #5 had a fall around 12:15 a.m., hit their head, and neurological checks were initiated; the resident had a 3-centimeter x 1-centimeter skin tear to the right forearm, swelling above the left lip, and had a brief nosebleed from the right nostril. The physician was notified via fax of the incident. A Health Status Note, dated [DATE], at 1:00 a.m., revealed swelling above the left upper lip and bruising developing around the left eye. An Orders – Administration Note, dated [DATE], at 1:02 a.m., revealed that Resident #5 was complaining of pain in the left rib area and was given acetaminophen 650 milligrams. A Skin/Wound Note, dated [DATE], at 1:07 a.m., revealed the skin tear on the right forearm was cleaned and then closed with four (4) steri-strips. A Health Status Note, dated [DATE], at 6:33 a.m., revealed Resident #5 attempted to stand to use the restroom with a walker and became dizzy; the resident attempted to use a urinal and was unsuccessful, but the urge to urinate left. A Transfer to Hospital Summary note, dated [DATE], at 10:25 a.m., revealed Resident #5 continued complaining of nausea and dizziness after the fall, and when a nurse assessed the resident, they also complained of head pain and having significant pain to the ribs on the left side. The physician was contacted via telephone, and the resident was sent to the hospital. A Health Status Note, dated [DATE], at 5:37 p.m., revealed that Resident #5 was admitted to the hospital for a brain bleed, pneumothorax, and left rib fractures. During an interview, on 8/28/25, at 3:15 p.m., with Administrative Nurse A, they stated that there was no notification at the time of the fall other than the fax to the physician.
§ 51.90 (b) (1) – (5) Abuse. The resident has the right to be free from mental, physical, sexual, and verbal abuse or neglect, corporal punishment, and involuntary seclusion. (1) Mental abuse includes humiliation, harassment, and threats of punishment or deprivation.	Based on interviews, record review, and policy review, the facility failed to ensure residents were free from abuse for three (3) of 22 sampled residents (Resident #21, Resident #22, and Resident #7). The findings include: Review of the policy titled, “Abuse Prevention Program,” revised 8/20/18, revealed the Illinois Department of Veteran Affairs “has

(2) Physical abuse includes hitting, slapping, pinching, or kicking. Also includes controlling behavior through corporal punishment. (3) Sexual abuse includes sexual harassment, sexual coercion, and sexual assault. (4) Neglect is any impaired quality of life for an individual because of the absence of minimal services or resources to meet basic needs. Includes withholding or inadequately providing food and hydration (without physician, resident, or surrogate approval), clothing, medical care, and good hygiene. May also include placing the individual in unsafe or unsupervised conditions. (5) Involuntary seclusion is a resident's separation from other residents or from the resident's room against his or her will or the will of his or her legal representative. **Level of Harm** –Actual Harm that is not immediate jeopardy **Residents Affected** – Few	a Zero [0] Tolerance for any form of resident abuse." It further revealed that employees were required to immediately report any incident, allegation, or suspicion of potential abuse to Administrative Staff A. Review of Resident #21's clinical record revealed the resident was admitted on [DATE], with diagnoses that included Severe Dementia, Generalized Anxiety Disorder, and Cerebral Infarction. Resident #21's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview of Mental Status (BIMS) of one (1), which indicated severe cognitive impairment. Review of Resident #22's clinical record revealed the resident was admitted on [DATE], with diagnoses that included Dementia. Resident #22's Quarterly MDS, with an ARD of [DATE], revealed a BIMS of zero (0), which indicated severe cognitive impairment. Review of the facility investigation revealed that an initial incident report was submitted, on [DATE], to the State Agency which involved an allegation of abuse of Resident #21 and Resident #22 perpetrated by Certified Nurse Aide A. Certified Nurse Aide B observed Certified Nurse Aide A being verbally and physically aggressive toward Resident #21 and Resident #22. Certified Nurse Aide A grabbed Resident #22's arms and pinned them down; the resident was swinging their arms, and Certified Nurse Aide A grabbed their fingers and bent them back; they told Resident #22 they were going to perform a wrestling move on them. Certified Nurse Aide B and Certified Nurse Aide A then went to assist Resident #21. Certified Nurse Aide A asked the resident to roll over and the resident said they did not think they could do that, so Certified Nurse Aide A aggressively grabbed the resident and rolled them over. Certified Nurse Aide A and Resident #21 got into a verbal altercation as the certified nurse aides attempted to dress Resident #21. Then Certified Nurse Aide A squeezed Resident #21's arms together. During an interview, on 8/27/25, at 3:00 p.m., with Administrative Staff A, they stated that Certified Nurse Aide A was suspended and asked to leave the building immediately when Certified Nurse Aide B reported the suspected abuse against Resident #22 and Resident #21. Certified Nurse Aide A was terminated for the substantiated abuse allegation. Review of Resident #7's clinical record revealed the resident was admitted on [DATE], with diagnoses that included Cerebral Infarction and Diabetes. Resident #7's Admission MDS, with an ARD of [DATE], revealed a BIMS of 12, which indicated moderate cognitive impairment.

	During an interview, on 8/28/25, at 2:50 p.m., with Resident #7, they said they had had a knee replacement in the past, and the certified nurse aide that was helping them did not like them complaining about pain while they were being transferred with the mechanical lift. Resident #7 told the certified nurse aide to leave their room and the certified nurse aide continued to mouth off. The certified nurse aide refused to leave and was speaking negatively about the resident in the hall. They said the staff member had not worked with them since. During an interview, on 8/27/25, at 3:00 p.m., with Administrative Staff A, they said the abuse against Resident #7 was reported to the facility immediately on [DATE], initially reported to the state the same day, investigated, substantiated, and the final investigation was reported to the State Agency. The staff member was terminated, but was appealing the termination. Administrative Staff A would update Resident #7 once the termination was final because it was still moving through the administrative process.
§ 51.110 (e) (1) Comprehensive care plans. (1) The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following— (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §51.120; and (ii) Any services that would otherwise be required under §51.120 of this part but are not provided due to the resident's exercise of rights under §51.70, including the right to refuse treatment under §51.70(b)(4) of this part. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview, record review, and policy review, the facility failed to revise the Care Plan to attain the resident's highest practicable physical, mental, and psychosocial well-being for one (1) of 22 sampled residents after the resident suffered a fall with major injuries (Resident #5). The findings include: Review of the policy titled, "Care Plan," reviewed 7/17/13, revealed: "personnel who note a change of condition in member make written suggestions for Care Plan change and submit to Administrative Nurse A or designee." Review of Resident #5's clinical record revealed the resident was admitted on [DATE], with diagnoses that included Chronic Atrial Fibrillation and Diabetes. Resident #5's Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview of Mental Status (BIMS) score of seven (7), which indicated severe cognitive impairment. Review of Resident #5's Care Plan revealed no new interventions after the fall with major injuries on [DATE]. A Communication with Physician progress note, dated [DATE], at 12:50 a.m., revealed that Resident #5 had a fall around 12:15 a.m., hit their head, and neurological checks were initiated; the resident sustained a 3-centimeter x 1-centimeter skin tear to the right forearm, swelling above the left lip, and had a brief

	nosebleed from the right nostril. The physician was notified via fax of the incident. A Health Status Note, dated [DATE], at 5:37 p.m., revealed that Resident #5 was admitted to the hospital for a brain bleed, pneumothorax, and left rib fractures. During an interview, on 8/28/25, at 3:15 p.m., with Administrative Nurse A, they stated that the Care Plan should have been updated after the fall with major injuries, and confirmed that no update was done. They stated that it was missed.
§ 51.120 Quality of care. Each resident must receive and the facility management must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **Level of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	Based on interview, record review, and policy review, the facility failed to ensure each resident was provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with standards of care for one (1) of 22 sampled residents by not administering the complete course of antibiotics prescribed (Resident #9). The findings include: Review of the policy titled, "Physician's Orders," dated 8/23/23, revealed that: "Physician orders must be checked by a [nurse] and initiated in a timely manner. Administer medications as ordered by the physician and follow special instructions (to include manufacturer instructions) for each specific medication." Review of Resident #9's clinical record revealed the resident was admitted on [DATE], with diagnoses that included: Paraplegia and Diabetes. Resident #9's Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed a Brief Interview of Mental Status (BIMS) of 12, which indicated moderate cognitive impairment. A Transfer to Hospital Summary note, dated [DATE], at 12:09 p.m., reflected that Resident #9 drove their electric wheelchair into a treadmill in the therapy gym while maneuvering an obstacle course. There was visible deformity to the left foot and bleeding, so Resident #9 was sent to the Emergency Department. An Emergency Department discharge summary, dated [DATE], revealed a laceration to three (3) toes on the left foot that required sutures, and a fracture of the distal metatarsal that required a splint. It further revealed an order for "Cephalexin (Keflex) 500 mg capsule, take one (1) capsule by mouth four (4) times a day for five (5) days."

	Review of the facility Keflex order, entered [DATE], at 8:14 p.m., reflected instructions to take "500 mg capsule, take one (1) capsule by mouth four (4) times a day for five (5) days," with a start date of [DATE], and stop date of [DATE]. Review of Resident #9's [DATE] Medication Administration Record (MAR) revealed that Resident #9 received 1 dose of Keflex on: [DATE] at 9:00 p.m. [DATE] at 8:00 a.m. [DATE] at 12:00 p.m. [DATE] at 5:00 p.m. [DATE] at 9:00 p.m. [DATE] at 8:00 a.m. [DATE] at 12:00 p.m. [DATE] at 5:00 p.m. [DATE] at 9:00 p.m. [DATE] at 8:00 a.m. [DATE] at 12:00 p.m. [DATE] at 5:00 p.m. [DATE] at 9:00 p.m. [DATE] at 8:00 a.m. [DATE] at 12:00 p.m. [DATE] at 5:00 p.m. [DATE] at 9:00 p.m. No record of administration of the last three (3) doses of prescribed Keflex was found. During an interview, on 8/28/25, at 9:21 a.m., with Administrative Nurse A, they stated that three (3) doses of the Keflex were not administered. They further stated that the cause of the problem was putting the stop date of [DATE], and had the nurse not entered the stop date, the order entry system in the electronic medical record would have populated the correct number of administrations of the medication. They stated that all nurses were being in-serviced about the issue to prevent recurrence of the problem.
§ 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.	Based on observations, interviews, record review, and review of the facility policy and procedures, the facility failed to provide adequate supervision for: 1. one (1) of one (1) sampled resident (Resident #2) who smoked, and 2. one (1) of one (1) (Resident #4) reviewed for elopement. These failures had the potential for residents to encounter an avoidable accident.

Level of Harm – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	The findings include: 1. A review of the facility's policy titled, "Smoking," dated May 2015, read: "2. Cigarettes, or smoking materials should be removed from all members who need supervision. These materials should be kept at a designated area. 3. Violation of the Smoking Policy and Procedure will be reported on an IVHA-[Illinois Veteran's Home – Anna] Incident Report." The facility admitted Resident #2 on [DATE] with diagnoses including Stroke with hemiplegia and hemiparesis affecting the left dominant side, seizures, and dementia. The most current Annual Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was conducted and the resident was coded as three (3), which indicated severe cognitive impairment. Review of the Care Plan Report, revised on [DATE], documented that Resident #2 was at risk for a smoking injury because they appeared to be asleep with a lit cigarette. The goal listed was that Resident #2 would be safe while smoking, which was initiated [DATE]. The immediate interventions included a discussion with the resident and to perform another smoking evaluation. A smoking apron was to be offered if they appeared to be asleep with lit cigarettes again, and smoking materials were to be kept locked in a safe place. It was noted that staff would assist Resident #2 to sign out their cigarettes on a form so that they were able to see how many packs they had taken out and how many they had left. Review of Resident #2's electronic medical record revealed a "Smoking Evaluation," dated [DATE], which documented the nursing staff saw the resident asleep in the [LOCATION] with a lit cigarette in their hand, and when questioned, they stated that they were not asleep, but simply had their head down. The resident was reminded of the smoking policy and that if this occurred again, they would be expected to wear a smoking apron. Further review of Resident #2's electronic medical record revealed a "Smoking Evaluation," dated [DATE], which documented the resident had cognitive loss, visual deficits, and dexterity problems. Resident #2 smoked more than 10 cigarettes a day. The required smoking interventions checked were that smoking materials were to be secured by staff for their safety. Resident #2 was noted as safe to smoke without supervision. The initial tour of the facility on 8/26/25 at 2:00 p.m. identified the facility had a [LOCATION] with a video camera that was facing the table in the room.

	During an observation, on 8/26/25, at 12:00 p.m., it was observed that there were no staff at the [LOCATION] to watch the camera for those who smoked in the [LOCATION]. During an observation, on 8/27/25, at 9:45 a.m., Resident #2 was observed in the [LOCATION] lying their head on the table. The resident was not observed to be holding a cigarette. During a concurrent observation and interview, on 8/27/25, at 10:50 a.m., Resident #2 was observed in the [LOCATION] with their head down and eyes closed. The surveyor asked Resident #2 if they fell asleep with a lit cigarette, and they said: “No.” The surveyor then asked the resident if they fell asleep in the [LOCATION], and again the resident said: “No.” During an observation, on 8/27/25, at 10:53 a.m., at the [LOCATION], surveyors asked to see their video camera of the [LOCATION]. The camera was a small video camera with approximately three (3) inch by three (3) inch screen resembling a baby monitor located behind their computer, and the camera was covered up by paper that the staff member removed. The camera was unclear. Resident #2’s silhouette was seen, but the video was not clear. During an interview, on 8/27/25, at 11:10 a.m., with Administrative Staff A, they agreed that nursing staff could not be at the [LOCATION] all the time to watch the camera when Resident #2 was in the [LOCATION]. Administrative Staff A stated that staff was union, and refused to sit in the [LOCATION] and endure a smoke-filled room. Administrative Staff A agreed the camera they used was not the best quality, and they would look into getting a better-quality camera to use. Administrative Staff A stated that Consultant Staff A reassessed Resident #2’s smoking safety evaluation. Resident #2 stated that they were taking away their freedom by recommending they wear a smoking apron. The facility did not provide the incident report, dated [DATE], upon request regarding Resident #2, who fell asleep with a lit cigarette. During an observation, on 8/27/25, at 12:15 p.m., no staff were observed at the [LOCATION] to watch the camera for those who smoked in the [LOCATION]. During a concurrent observation and interview with Resident #2 on 8/27/25 at 12:41 p.m. in the [LOCATION], Resident #2 stated they kept their cigarettes and lighter, and stored them on their bedroom table.

	During an interview, on 8/27/25, at 12:44 p.m., Licensed Nurse A stated Resident #2 checked out one (1) lighter, and they turned in their cigarettes to the staff. Licensed Nurse A stated the resident kept their lighter, but only could have one (1) at a time. Licensed Nurse A indicated Consultant Staff A was responsible for completing the smoking evaluations. During an observation, on 8/27/25, at 1:30 p.m., with the Administrative Nurse A in the [LOCATION], Administrative Nurse A woke Resident #2. Resident #2 was asleep with their head down and a pack of cigarettes were next to them. During an interview, on 8/27/25, at 1:55 p.m., with Consultant Staff A, they stated they evaluated residents to ensure smoking safety. Consultant Staff A stated that Resident #2 needed to go to check out cigarettes because they chain smoked, and this way the staff could spread out the cigarettes they smoked. Consultant Staff A stated they confiscated a piece of their favorite clothing because staff came to them concerned that Resident #2 burned holes in their clothing. They stated they were not sure if they were burned holes in the clothes or they were worn out. Consultant Staff A stated they were not concerned about Resident #2's safety unless they fell asleep with a cigarette in their hand. Consultant Staff A stated the resident had nothing else to do other than smoke. During several observations, on 8/27/25, and 8/28/25, throughout the day, Resident #2 was observed in the [LOCATION] asleep, sitting in a chair with their head down or head lying on the table. No observations were made of staff checking on the resident during any of the observations. The room smelled of smoke. No lit cigarettes were observed. During an observation, on 8/27/25, at 2:15 p.m., Resident #2 was observed in the [LOCATION] head and chin down with their eyes closed. The [LOCATION] smelled of smoke, and extinguished cigarettes and ashes were in the ashtray on the table. 2. Review of the facility's policy titled, "Resident Safety and Supervision," last reviewed 8/15/24, indicated: "All residents with Wander Guards will have documented placement and function checks each shift." Review of the "Missing Member" policy, last revised 7/22/25, directed staff to provide for the quick, efficient, and safe return of any missing member. A review of an initial elopement assessment, done [DATE], revealed Resident #4 was a high wander risk with a score of

	eight (8), and a score of six (6) or greater indicated elopement risk. A review of Resident #4's quarterly elopement risk, completed on [DATE], indicated that they continued to be a high wander risk, with a score of seven (7), and a score of six (6) or greater indicated elopement risk. Review of the Door Alarm Check form, dated [DATE], revealed the [LOCATION] door inside, and [LOCATION] door did not alarm. The door check form indicated all other doors alarmed. Review of Resident #4's Discharge Summary, dated [DATE], revealed the resident was admitted from an assisted living facility on [DATE]. The summary indicated Resident #4's Dementia progressed, and they wandered around the facility and continued to be an elopement risk. It was noted that the resident would benefit from a locked [LOCATION]. Resident #4 was admitted to the facility on [DATE], from home, with diagnoses that included Frontotemporal Dementia, Anxiety, History of Psychosis, and Major Depression. The Plan of Care, dated [DATE], revealed Resident #4 had impaired thought processes and was at risk for wandering and elopement. The Plan of Care focus was revised on [DATE], to indicate exit seeking; on [DATE], to indicate wandering at night into peers' rooms; on [DATE], to indicate "Behavior;" on [DATE], to indicate "Egressed;" on [DATE], to indicate they were difficult to redirect; on [DATE], it was noted to "Refer to senior lifestyles;" and [DATE], it was noted to "refer to psychiatric services." Resident #4's Treatment Administration Record confirmed Wander Guard placement and function was checked every shift from [DATE] through their discharge from the facility. A [DATE] Restorative Program Note, written on [DATE] at 11:53 a.m., noted that Resident #4 "wanders aimlessly r/t [related to] cognitive status. Up and down halls and into various places…When [they pace], this can last several hours and is mostly at night. Often attempting to elope…continues to wear a wanderguard and is high flight risk" [sic]. Review of the facility incident report for [DATE], found documented that at 2:48 a.m., at approximately 12:45 a.m.: Resident #4 was eating ice cream at the [LOCATION]. Approximately 5 minutes later, staff were unable to locate Resident #4, and a search ensued. During the search, the door in the [LOCATION] was found alarming. The facility and the grounds were searched. Administration and emergency services were notified. Resident #4 was discovered by staff two (2) streets away from the facility approximately 0.3 miles from

	the facility. Licensed Nurse B assessed, and no injuries were noted. Review of the Door Alarm Check form, dated [DATE], revealed the [LOCATION] door inside and the [LOCATION] door did not alarm. The door check form indicated all other doors alarmed. During an interview, on 8/27/25, at 3:00 p.m., with Administrative Staff A, they stated that Resident #4 eloped from the [LOCATION], the alarm was heard when nursing staff noticed the resident was not by the [LOCATION], and they searched the building. The alarm behind the nurse at the [LOCATION] did not alarm, even though all subsequent tests showed it was working, and the log showed the alarm was sent to the [LOCATION]. Administrative Staff A indicated it was a mystery as to why the alarm did not sound.