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: 10/14/25 – 10/17/25

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 190

Census on First Day of Survey: 81

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual Survey was conducted from October 14, 2025, through October 17, 2025, 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.
§ 51.110 (e) (2) Comprehensive care plans. A comprehensive care plan must be— (i) Developed within 7 calendar days after completion of the comprehensive assessment; (ii) Prepared by an interdisciplinary team, that includes the primary physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and	Based on record review and interview, the facility failed to ensure the residents' Comprehensive Care Plan was reviewed and revised for one (1) of three (3) residents whose Care Plans were reviewed for falls (Resident #1). The findings include: Review of facility policy titled, "CARE PLAN PROCESS," dated January 8, 2002, noted the following: "POLICY: The Interdisciplinary Committee will assure that each resident have an individualized plan of care, which is directed toward achieving and maintaining [their] optimal level of functioning…PROCEDURE: The Care Plan composition: 1. Identification of the resident's problems, needs, and strengths. 2. Measurable goals to meet those needs, solve the problems, and support their strengths. 3. Approaches, services and interactions to meet those goals…The committee, representing

(iii) Periodically reviewed and revised by a team of qualified persons after each assessment. **Leve of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	all areas of patient care, will meet on a regular basis to review the comprehensive assessment and to review the individual care plans for each resident…D. The residents'' plan of care will be reviewed, amended, and approved by the team, resident and family at the care plan review meeting" [sic]. Review of the medical record for Resident #1 was conducted and noted that Resident #1 was admitted to the facility on [DATE], and had diagnoses of Alzheimer's Disease, Muscle Weakness, Unspecified Dementia, and Anxiety. The medical record stated Resident #1 was rarely understood and was severely cognitively impaired. Review of Resident #1's Comprehensive Care Plan for falls, received 10/15/25, was conducted and noted that Resident #1 was at risk for falls due to confusion, gait, and balance problems and was unaware of safety needs. The Comprehensive Care Plan stated that, on [DATE], Resident #1 was placed on 15-minute checks due to falls. The Comprehensive Care Plan did not have a discontinuation date for the 15-minute checks. A review of fall investigations for Resident #1 found unwitnessed falls on [DATE], and [DATE]. The Care Plan was updated with both falls. Review of 15-minute checks logs entitled, "Visual Watch Log," only identified logs for the 72 hours following the falls, and not routine, daily logs per the Care Plan. An interview was conducted, on 10/16/25, with Administrative Nurse A. Administrative Nurse A stated that when a resident fell on the unit(s), the nurses would automatically place the resident on 15-minute checks for the next 72 hours. Administrative Nurse A stated they did not feel there was adequate monitoring of the 15-minute check sheets to ensure they were being completed per the Care Plan. Administrative Nurse A stated the facility needed to review their falls and Care Plan policies to ensure fall interventions were followed and effective. Administrative Nurse A stated the Comprehensive Care Plan for Resident #1, as noted above, stated that Resident #1 should have been on 15-minute checks since [DATE], and not only for 72 hours.
§ 51.110 (e) (3) Comprehensive care plans. The services provided or arranged by the facility must— (i) Meet professional standards of quality; and	Based on record review and interview, the facility failed to ensure services were provided to meet the needs of the residents as identified in the Care Plan for fall prevention. This affected one (1) of three (3) residents reviewed for Care Plans (Resident #1).

(ii) Be provided by qualified persons in accordance with each resident's written plan of care. **Leve of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Few	The findings include: Review of facility policy titled, "CARE PLAN PROCESS," dated January 8, 2002, noted the following: "POLICY: The Interdisciplinary Committee will assure that each resident have an individualized plan of care, which is directed toward achieving and maintaining [their] optimal level of functioning…PROCEDURE: The Care Plan composition: 1. Identification of the resident's problems, needs, and strengths. 2. Measurable goals to meet those needs, solve the problems, and support their strengths. 3. Approaches, services and interactions to meet those goals. 4. The disciplines of the individuals who will provide the services. 5. The timeframe set until the next evaluation which will be 30-days, quarterly or annual. The committee, representing all areas of patient care, will meet on a regular basis to review the comprehensive assessment and to review the individual care plans for each resident. The team members responsible for their particular areas of the care plan develop the care plan in accordance with the physician's orders, the resident's needs and state and federal guidelines…D. The resident's plan of care will be reviewed, amended, and approved by the team, resident and family at the care plan review meeting. If resident or family can not make a care plan meeting that is scheduled, the team will do their best accommodating another scheduled meeting or offering phone conference or summary at their request" [sic]. Review of the medical record for Resident #1 was conducted and noted that Resident #1 was admitted to the facility on [DATE], and had diagnoses of Alzheimer's Disease, Muscle Weakness, Unspecified Dementia, and Anxiety. The medical record stated Resident #1 was rarely understood and was severely cognitively impaired. Review of Resident #1's Comprehensive Care Plan for falls, received 10/15/25, was conducted and noted that Resident #1 was at risk for falls due to confusion, gait, and balance problems and was unaware of safety needs. The Comprehensive Care Plan stated that, on [DATE], Resident #1 was placed on 15-minute checks due to falls. The Comprehensive Care Plan did not have a discontinuation date for the 15-minute checks. A review of fall investigations for Resident #1 was conducted and noted the following: - [DATE]: Resident #1 had an unwitnessed fall. Resident #1 was found in their room lying on the floor by the bed. The

	fall investigation stated Resident #1 did not sustain any injuries. The fall investigation stated the intervention to prevent future falls from occurring was for Resident #1 to be placed on 15-minute checks for the next 72 hours, and to have a urinalysis conducted for possible infection. - [DATE]: Resident #1 had an unwitnessed fall. Resident #1 was found in their room lying on the floor by the bed. The fall investigation stated Resident #1 did not sustain any injuries. The fall investigation stated the intervention to prevent future falls from occurring was for Resident #1 to be placed on 15-minute checks for the next 72 hours, and urinalysis came back positive; awaiting Physician Orders to treat the infection. Review of 15-minute check logs entitled, "Visual Watch Log," from [DATE] – [DATE], was conducted and noted the following: - [DATE]: No 15-minute check documentation sheet provided. - [DATE]: No documentation of 15-minute checks was identified from 7:00 a.m. – 2:45 p.m. - [DATE]: No documentation of 15-minute checks was identified from 7:00 a.m. – 6:00 p.m. - [DATE]: No documentation of 15-minute checks was identified from 7:00 a.m. – 6:00 p.m. - [DATE]: No documentation of 15-minute checks was identified from 7:00 a.m. – 8:00 p.m. An interview was conducted, on 10/16/25, with Administrative Nurse A. Administrative Nurse A stated that when a resident fell on the unit(s), the nurses would automatically place the resident on 15-minute checks for the next 72 hours. Administrative Nurse A stated staff were to lay eyes on all residents who were placed on 15-minute checks every 15 minutes. Administrative Nurse A stated Resident #1 had a urinary tract infection (UTI), and was treated after their fall on [DATE], as noted above. Administrative Nurse A stated the facility did not have documentation of 15-minute checks for [DATE], and did not feel there was adequate monitoring of the 15-minute check sheets to ensure they were being completed per the Care Plan. Administrative Nurse A stated the facility needed to review their falls and Care Plan policies to ensure fall interventions were followed and were effective. Administrative Nurse A stated the Comprehensive Care Plan for Resident #1, as noted above, stated that Resident #1 should have been on 15-minute checks since [DATE], and not only for 72 hours.
§ 51.140 (h) Sanitary conditions. The facility must:	Based on observation, interview, and policy review, the facility failed to ensure foods were stored, prepared, and distributed under sanitary conditions. Specifically, the facility failed to

(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. **Leve of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected –** Many	discard expired foods in one (1) walk in freezer, and moldy foods in one (1) of two (2) walk in refrigerators. This failed practice had the potential to affect all residents eating meals out of the [LOCATION]. The findings include: A review of the facility policy titled, "Food Storage Standards," dated 10/18/23, revealed: "Policy: All employees will adhere to the food storage standards established by Illinois Veterans Home (IVH) -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. Criteria for Freezer Storage: …h. All prepped and/or leftover items will be placed in sealed containers, clearly labeled with the names of the contents, and date for storage. i. Any item not stored as directed will be discarded." A tour of the [LOCATION] was conducted on October 14th, 2025, beginning at 9:50 a.m., with Dietary Staff A. An observation revealed three (3) clear plastic bags labeled "Chopped Steak," with ice buildup on the meat, and a written expiration date of 8/19, were sitting on the second shelf of the walk-in freezer. An observation revealed four (4) disposable pans covered with aluminum foil labeled "Coffee Cake," with an expiration date of 8/19, were stacked up on the bottom shelf of the main freezer. An observation revealed that one (1) large plastic bag of baked goods had no label to identify what was in the bag and had no expiration date. An observation revealed four (4) large plastic bags of smashed bananas were sitting on the third shelf of the freezer and had an expiration date of 8/27. An observation revealed two (2) plastic containers with moldy strawberries were sitting in a produce box on the 2nd shelf of the walk-in cooler. During an interview, on October 14, 2025, at 10:49 a.m., Dietary Staff A stated: "The date written on things is the date the food expires and should be thrown out. The freezers and coolers should be checked daily for any expired foods." During an interview, on October 15th, 2025, at 11:40 a.m., Dietary Staff 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.
§ 51.200 (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. **Leve of Harm** – No Actual Harm, with potential for more than minimal harm **Residents Affected** – Many	**Fire Safety and Operations** Based on record review and interview, the facility failed to conduct all the required fire drills. The deficient practice affected 12 of 12 smoke compartments, staff, and all residents. The facility had a capacity for 190 beds with a census of 81 on the first day of the survey. The findings include: Record review, on 10/14/25, at 1:26 p.m., revealed that no documentation was present to indicate the facility had conducted a fire drill on the second and third shifts for the fourth quarter of 2024. The facility failed to conduct fire drills quarterly on each shift in each building, as required by section 19.7.1.6 of NFPA 101, Life Safety Code. An interview with Maintenance Staff A, on 10/14/25, at 1:26 p.m., revealed the facility was not aware that any fire drills had been missed, and the state had not cited the facility for missing any fire drills during their most recent survey, and that documentation of the fire drills may have been misplaced at that time. The census of 81 was verified by Administrative Staff A on 10/14/25, at 9:32 a.m. The findings were acknowledged by Administrative Staff A and verified by Maintenance Staff A during the LSC exit interview on 10/15/25, at 10:00 a.m. **Actual NFPA Standard: NFPA 101, Life Safety Code (2012)** **19.7.1.4*** Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. **19.7.1.5** Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. **19.7.1.6** Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. **19.7.1.7** When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms.