

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IL6015481</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/29/2018</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ILLINOIS VETERANS HOME AT LASALLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 O'CONNOR AVENUE LA SALLE, IL 61301</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Facility Reported Incident 8/21/18/IL105344</p> <p>The Illinois Veterans Home at Lasalle is in compliance with the Illinois Veteran's Home Code (77 Illinois Administrative Code 340) for this survey.</p>	S 000		

Illinois Department of Public Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_