

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6014120	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2018
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NAME OF PROVIDER OR SUPPLIER ILLINOIS VETERANS HOME - ANNA	STREET ADDRESS, CITY, STATE, ZIP CODE 792 NORTH MAIN ANNA, IL 62906
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(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>Annual Licensure Survey</p> <p>Complaint 1854073 / IL103628</p> <p>The Illinois Veterans Home, Anna is in compliance with the 77 Illinois Administrative Code 340, Requirement for Long Term Care Facilities for this survey.</p>	S 000		

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