Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6011332	A. BUILDING: ______ B. WING ______	C 01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE AT VICTORY LAKES, THE	1055 EAST GRAND AVENUE LINDENHURST, IL 60046

(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	Initial Comments Complaint Investigation 2410047/IL168329	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 c) 300.1210 d)3) 300.1210 d)5) 300.1220 b)3) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. 5) A regular program to prevent and	S9999		

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treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

These requirements are not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess and identify a resident's pressure injury to her right lower leg until it was a stage 3 acquired pressure injury from a medical device. This applies to 1 of 3 residents (R2) reviewed for acquired pressure injuries in the sample of 3.

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This resulted in R2 sustaining a facility acquired stage 3 pressure injury.

The findings include:

R2's face sheet shows R2 is 91 year old who was originally admitted to the facility on 10/11/23, with diagnoses that include right femur fracture that had undergone hip surgery, history of falling, and diabetes.
,
R2's Braden scale (predicting pressure score risk), dated 10/30/23, shows R2 is at risk for developing pressure.

R2's skin admission assessment, dated 10/11/23, shows R2 had no pressure injury except a surgical incision to right hip.

R2's hospital discharge summary, dated 10/11/23, shows an order for R2's right lower extremity to be non weight bearing, and the knee immobilizer to be on at all times.

R2's care plan, dated 10/12/23, shows R2 was at risk to develop further skin breakdown, but did not include R2's use of the immobilizer or any care that needs to be done when wearing a knee immobilizer.

R2's Wound Evaluation Management Summary, dated 11/1/23, was when R2's pressure injury was discovered to her right lower lateral calf that was a stage 3 measuring 6.5 centimeters (cm) x 2.5 cm x 0.1 cm.

The Facility Wound Report, dated 1/3/23, provided to this surveyor shows R2's facility acquired pressure injury to her right lower lateral calf was now a stage 4 measuring 3.5 cm x 1.0

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cm x 0.1 cm .

On 1/3/24 at 10AM, R2 was in bed on a low air loss mattress. R2's right leg was suspended with a pillow. R2 said she fell at home, hurt her right leg, and had surgery. R2 said she now has a wound at the back of her right leg, but cannot recall what happened. V4 (Wound Nurse), who was also in R2's room, showed this surveyor R2's pressure injury to right lower lateral calf. A huge open wound was noted at the back of R2's right lower leg. V4 said R2's acquired pressure injury came from R2's knee immobilizer (medical device) she was using before. V4 then opened a closet, took a knee immobilizer, and showed this surveyor that this was R2's knee immobilizer. The knee immobilizer has velcro on the side. V4 pointed a hard area at the back part of the immobilizer, and said R2's right lower leg was laying directly on the hard part of the immobilizer; that had caused pressure injury on R2's right lower leg (calf). V4 said R2 was complaining of discomfort to that area. V4 said when the immobilizer was removed to check the skin, V4 had a stage 3 open area to her right lower leg V4 said the order was for R2 to use the immobilizer at all times, but typically, the skin can be checked during care.

On 1/3/24 at 10:20 AM, V6 (Wound Doctor) said she took over R2's wound care for the past 4 weeks now. V6 said, "(R2) has fragile skin and is also a diabetic. Wearing a knee immobilizer has the potential risk to cause the development of pressure injury. Slight movements can cause the immobilizer to move that can cause skin frictions." V6 said it was important to check the placement of the immobilizer and inspect the skin underneath.

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S9999	Continued From page 4 On 1/3/24 at 2PM, V2 (Director of Nursing) said since the order of the knee immobilizer was on at all times, no one was checking the skin underneath. V2 also said the order was not clarified to the Ortho if it can be removed for skin checks. V2 also confirmed R2's immobilizer was not part of R2's Physician Order Sheets (POS). On 1/3/24 at 2:15 PM, V7 (R2's previous Wound Doctor) said, "(R2) had an order of wearing the immobilizer at all times from Orthopedic, but generally speaking, when a resident wears an immobilizer, staff has to check the skin from time to time as immobilizer can cause pressure or skin irritations." The facility presented a document entitled Unavoidable Pressure Injury clinical condition, dated 1/4/24. The facility also presented a document from the Orthopedic MD, dated 1/4/24, that R2 has to wear the knee immobilizer until 11/13/23. (B)	S9999		