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 _____	02/07/2024

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 Annual Licensure and Certification Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210b)5) 300.1210d)6) 1 of 2 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

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 _____	02/07/2024

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
S9999	Continued From page 1	S9999		

resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on observation, interview and record review the facility failed to ensure residents were transferred in a safe manner. This failure resulted in R432 being sent to the hospital for 8 days due to increased pain after a transfer. This applies to 1 of 18 residents (R432) reviewed for safety in the sample of 18.

The findings include:

R432's Face Sheet shows that he originally admitted to the facility on 1/7/24.

R432's Physical Therapy Evaluation dated 1/8/24 shows that he was referred to therapy for strengthening and decrease level of assistance in bed mobility and transfer. The report shows, "

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 _____	02/07/2024

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
S9999	Continued From page 2	S9999		

Patient exhibiting difficulty performing bed mobility, transfer, sitting balance and ability to stand." The assessment shows that he needs maximum assistance of 2 people for transfer and is dependent on staff for bed-to-chair transfers and has no reports of pain. The assessment shows that R432 is alert and oriented to person, place and time.

On 2/5/24 at 1:50 PM, R432 said that he had to go to the hospital due to severe back pain after an incident with a transfer. R432 said that he was using the slide board to transfer from his wheelchair to his bed. R432 said that once he got to the side of the bed, the aide that was behind him came to the front of him and he fell back in bed because no one was supporting his upper half and he hurt his back. R432 said that the pain was a "12 out of 10." R432 said that it was horrible. R432 said that before the incident he would have back pain when he moved but it was only at a 6 out of 10. R432 stated, "I had to go to the hospital after that. I could not even lay in the MRI machine, it hurt so bad. They had to sedate me."

R432's History and Physical dated 1/8/24 shows, "admitted with spinal stenosis with lumbar myelopathy...lumbar fusion and spinal cord stimulator. He is feeling better."

R432's Rehabilitation Practitioner Note dated 1/9/24 shows that his pain is 4-5 out of 10....Bed mobility maximal assistance x 2. Slide board transfers-maximal to total assist of 2..."

R432's Nursing Note dated 1/10/24 at 5:36 PM shows, "Resident complained of severe pain 10/10 stated that he had never felt this bad before and was very concerned. Given norco as

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 _____	02/07/2024

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
S9999	Continued From page 3	S9999		

ordered with relief. Called [Physician] and made aware. New order received for stat x-ray of the lumbar spine and lidocaine patch..."

R432's Nursing Notes dated 1/13/24 at 10:00 PM shows, "patient complained of pain while sitting in his wheelchair. He is scheduled for PT Norco 5/325 1 tab given at 3:26 PM. He refused to go to therapy due to pain. Patient was put back to bed with 2 assist using the sliding board....pain is getting worse per patient 10/10 and unbearable want to go to hospital requesting to call 911....picked up the patient at 4:48 PM."

R432's Hospital Notes dated 1/13/24 shows, "Presents to ED (Emergency Department) chief c/o (complaint of) low back pain; today while in PT (Physical Therapy), fell backwards onto mattress.....Patient requiring multiple doses of narcotics to manage his pain; doesn't feel safe returning to rehab. Plan for admission for pain control, symptom stabilization." R432's Hospital Notes dated 1/14/24 shows, "Patient reports he had been doing fair at SNF (Skilled Nursing Facility), but still with significant weakness. Patient reports he had a fall/injury to his back earlier this week while working with PT, for which he was started on a medrol dose pack (steroids) on 1/11. Then today patient was again working with PT and fell backwards on to the bed and had acute worsening of his left sided low back pain of which he presents today.....pain control-oxycodone (narcotic pain medication), flexeril (muscle relaxer), lidocaine and diclofenac patches, hydromorphone (narcotic pain medication) for breakthrough..."

On 2/6/24 at 11:18 AM, V7 (Nurse Supervisor) said that R432 was a slide board transfer and was complaining of increased pain after a

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 _____	02/07/2024

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
S9999	Continued From page 4	S9999		

transfer. R432 was sent to the hospital for a few days and came back with an increase in pain medication and is now a mechanical lift transfer.

On 2/6/24 at 1:18 PM, V21 (Nurse Practitioner) said that R432 was re-admitted to the hospital for severe back pain but she was unaware of any incidents that happened that caused the pain.

On 2/7/24 at 8:58 AM, V23 (Occupational Therapist) said that when R432 was first admitted, he was able to use the slide board for transfers with two people. V23 said that when R432 first came in, he was unable to sit on the side of the bed independently. V23 said that for a two person assist slide board transfer, the patient should be assisted from the wheelchair to the bed by placing the slide board between the bed and the chair. V23 said that once the resident is in bed, one person should assisted with his trunk due to poor trunk control and one person should assist with his legs and move him to a laying positron in one swift movement so there would be no strain on the back especially with his history of back problems. V23 said that R432 needs assistance with trunk support at all times unless he would fall over in bed.

On 2/7/24 at 9:24 AM, V24 (Certified Nursing Assistant) said that himself and another aide put R432 to bed on the evening of 1/10/24. V24 said that they used the slide board. V24 said that after a resident is assisted to the side of the bed with the slide board, one person would direct the resident's feet and one person would direct their trunk. V24 said that he did not remember if he was assisting with the feet or trunk. V24 said that he did not remember if R432 fell back in bed or not and V24 said that he did not remember if R432 complained of pain after the transfer.

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 _____	02/07/2024

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
S9999	Continued From page 5	S9999		

R432's Face Sheet shows that he was readmitted to the facility on 1/21/24.

R432's Physical Therapy Evaluation dated 1/22/24 shows he requires maximum assistance of two persons for bed mobility and totally dependent on staff for transfers and is in severe pain.

R432's Medication Administration Record (MAR) for January shows that between 1/7/24 and 1/10/24 he was taking a lidocaine patch to his lower back daily and norco 5/325 milligrams (mg)-1 tablet every 4 hours as needed for pain. R432 took the norco five times for pain of 4 to 7 out of 10. After 1/10/24, R432 took norco 5/325 mg-1.5 tablets every 4 hours as needed for pain 12 times between 1/10/24 and 1/13/24 for pain of 3 to 10 out of 10. R432's MAR shows that when re-admitted from the hospital on 1/21/24 he was ordered oxycodone 5 mg every 4 hours as needed for pain and flexeril 5 mg every 8 hours as needed for muscle spasms.
(B)

2 of 2
300.610a)
300.1210b)
300.1210c)
300.1210d)6)
300.1220b)3)
300.2040b)1)2)
300.2040c)
300.2040e)
Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall

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 _____	02/07/2024

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
S9999	Continued From page 6	S9999		

be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

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. Restorative measures shall include, at a minimum, the following procedures:

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:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

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 _____	02/07/2024

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
S9999	Continued From page 7 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. Section 300.2040 Diet Orders b) Physicians shall write a diet order, for each resident, indicating whether the resident is to have a general or a therapeutic diet. The attending physician may delegate writing a diet order to the dietitian. 1) The resident's diet order shall be included in the medical record. 2) The diet shall be served as ordered c) A written diet order shall be sent to the food service department when each resident is admitted and each time that the resident's diet is changed. Each change shall be ordered by the physician or dietitian. The diet order shall include, at a minimum, the following information: name of	S9999		

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 _____	02/07/2024

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
S9999	Continued From page 8	S9999		

resident, room and bed number, type of diet, consistency if other than regular consistency, date diet order is sent to the food service department, name of physician or dietitian ordering the diet, and the signature of the person transmitting the order to the food service department.

e) A therapeutic diet means a diet ordered by the physician or dietitian as part of a treatment for a disease or clinical condition, to eliminate or decrease certain substances in the diet (e.g., sodium) or to increase certain substances in the diet (e.g., potassium), or to provide food in a form that the resident is able to eat (e.g., mechanically altered diet).

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a resident with a diagnosis of dyspagia was supervised during meals and failed to ensure a resident was provided nectar thick liquids as ordered. This applies to 3 of 18 residents (R5, R7, and R44) reviewed for safety in the sample of 18.

1. R5's care plan dated 11/20/23 showed R4 was at risk for choking or aspiration due to her diagnoses of dysphagia and dementia. The care plan showed R5 had a history of pneumonitis due to aspirating food and/or fluids. The care plan showed R5 "will be assisted by CNAs (certified nursing assistant) if she eats in her room...Needs supervision during meals, cut foods into small pieces and redirect the resident to chew and swallow one at a time, slowly..."

R5's hospital records showed R5 was hospitalized on 12/7/23 with a diagnosis of

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 _____	02/07/2024

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
S9999	Continued From page 9	S9999		

gastrointestinal bleeding. R5's hospital speech therapy evaluation dated 12/8/23 showed R5 required a mechanical soft with nectar thick liquids due to her risk of choking. The evaluation showed R5 must be fed by staff to ensure R5 was eating slowly and was following the recommended feeding cues. The evaluation showed R5 was not to have straws in her drinks due to her choking risk. R5 was discharged from the hospital, back to the facility, on 12/14/23.

On 2/5/24 at 11:56 AM, R5 was in bed, eating lunch. No staff were present in R5's room. R5 swiftly scooped food into her mouth; occasionally dropping food onto her lap. No coughing was noted from R5. Two Styrofoam cups with lids and straws, one containing thickened coffee and the other thickened water, were noted on the tray, directly in front of R5.

On 2/5/24 at 1:03 PM, R5 remained in bed. One Styrofoam cup, with a lid and straw, was noted in front of R5 on her bedside table. The contents of the cup appeared to be non-thickened water. V8 Licensed Practical Nurse (LPN) entered R5's room. She picked up the cup, opened the lid and shook the cup, and stated, "That's regular water. That's not thickened." V8 closed the cup and placed it back down in front of R5. V8 exited the room.

On 2/6/24 at 9:39 AM, V9 Speech Therapist (ST) stated R5 has dysphagia that is chronic and ongoing. V9 stated R5's last speech therapy session was 12/5/23. V9 had not evaluated R5 since she had been readmitted from the hospital on 12/14/23. V9 stated, "I saw her in December because staff had reported she was coughing during meals. Upon evaluation, I downgraded her diet to mechanical soft and regular liquids.

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 _____	02/07/2024

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
S9999	Continued From page 10	S9999		

Upon her discharge from me, I said she needed direct, 1:1, supervision when eating due to her dysphagia and tendency to eat to fast. It looks like her fluids were changed to nectar thick in the hospital... I also see the (physician) order for no straws. She has a tendency to drink and eat too fast. Straws have a tendency to make people gulp and drink faster. That's why she probably shouldn't be using straws."

2 . R7's care plan dated 12/4/23 showed R7 required the use of a sit-to-stand (mechanical) lift, with the assistance of two staff, for all transfers and toileting due to her unsteady balance and generalized weakness.

On 2/5/24 at 11:41 AM, V10 CNA transferred R7, via sit-to-stand lift, from a wheelchair to the toilet. R7 was hanging onto the lift with her hands. R7's knees were bent as she was unable to bear weight and stand. No other staff were noted in R7's room.

On 2/6/24 at 9:31 AM, V2 Director of Nursing (DON) stated all resident transfers, via a sit-to-stand, are to be performed by two staff members, not one.

The facility's Lifting Machine, Using a Mechanical policy dated July 2017 showed, "At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift."

3. R44's care plan dated 12/20/23 showed R44 required the substantial assistance of one staff when being transferred from bed to wheelchair.

On 2/5/24 at 10:35 AM, V16 CNA transferred R44, from her bed to a wheelchair, by lifting R44 up, under her armpits, and pivoting her into the

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 _____	02/07/2024

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
S9999	Continued From page 11 chair. R44 was unable to bear weight during the transfer or hold onto V16. No gait belt was used during the transfer. On 2/6/24 at 9:31 AM, V2 DON stated gait belts are to be used to transfer any resident that requires staff assistance. The facility's Gait Belt policy dated 6/1/23 showed, "Gait belts are to be used for all transfers that require staff assistance and when assisting residents to ambulate." (B)	S9999		