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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) 300.1210a) 300.1210b) 300.1210c) 300.1210d)2) 300.1210d)5) 300.1220b)2)3) 300.1220b)7) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999		

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applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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:

2) All treatments and procedures shall be administered as ordered by the physician.

5) A regular program to prevent and 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

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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:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
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.
7) Coordinating the care and services provided to residents in the nursing facility.

These requirements were not met as evidence by:

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Based on observation, interview, and record review the facility failed to follow the Wound Physician's recommendations, failed to identify, report, and obtain treatment for wounds and failed to provide pressure relieving intervention to prevent the development of pressure ulcers for 4 of 9 residents (R73, R45, R135, R35) reviewed for pressure ulcers in the sample of 20. This failure resulted in R73's MASD-Moisture Acquired Skin Disease to the left and right gluteal area developing into a left gluteal Stage 3 and right gluteal Stage 4 pressure ulcer.

The findings include:

1. R73 Predicting Pressure Ulcer score risk dated 10/12/2024 (admission) shows, "High Risk"

On 01/28/25 at 11:11 AM, V2 DON-Director of Nurse changed the dressing for R73's Stage 4 pressure wound to the left buttock and the Stage 4 pressure wound to the left heel.

On 01/28/25 at 11:11 AM, V2 DON-Director of Nursing said, R73 did have redness to the right butt cheek upon admission but developed the pressure ulcer in the facility.

R73 Admission Assessment dated, 05/10/24 at 7:18 PM, shows, Skin MASD in buttocks - very red but intact, Dry scab at Right foot 2 x 1 cm (centimeter), Dry scab at left shoulder - no drainage noted, scattered bruises and scabs at arms and legs due to fall.

R73's Initial Wound Evaluation by V11 Wound Doctor dated 10/16/24 shows, unstageable Deep Tissue Injury of the Left Heel, etiology Pressure, Duration Less than 2 days. Size 8.3 cm x 4.1 cm. Skin intact with purple/maroon discoloration.

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S9999	Continued From page 4 Recommendations: Off-Load Wound; Float Heels in Bed; Pressure Off-Loading Boots. Stage 4 Pressure Wound of the Right Buttock Full thickness. Etiology Pressure Stage 4, duration greater than 14 days. Noted to be present on admission per staff. Wound size 2.6 cm x 1.1 cm x 0.5 cm centimeters. slough 10%. Stage 3 Pressure Wound of the Left Buttock Full Thickness. Etiology Pressure Stage 3, Duration greater than 14 days, noted to be present on admission per staff. Wound size 4.5 cm x 7.3 cm x 0.3 cm. 100% subcutaneous dermis. R73's Current Care Plan on 01/28/25 shows, V11's Recommendation to float heels in bed and to apply pressure off-loading boots has NOT been initiated as an Intervention in R73's Care Plan. R73's Wound Evaluation & Management Summary dated 11/27/24 by V11 Wound Doctor shows, Stage 3 pressure wound of the left buttock full thickness etiology pressure, stage 3, duration greater than 56 days noted to be present on admission per staff, 4.5 cm x 8.1 cm x 0.5 centimeters, 30% slough, 20% granulation, 50% subcutaneous dermis. Recommendations: Cipro 500 milligrams by mouth twice a day for 10 days started yesterday by primary care physician with positive cultures of wound and urinary tract infection. R73's MAR dated November 2024 and December 2024 shows, R73 did not receive the wound physicians recommended antibiotic of Ciprofloxacin 500 milligrams by mouth twice a day for 10 days between November 27, 2024, to December 6, 2024, for the Stage 3 Pressure Wound.	S9999		

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On 01/28/25 at 1:43 PM, V2 DON said, the nurse that is given the Physician Order is responsible to ensure it is performed. This would be the reasonability of the Wound Nurse to input the order to pharmacy, obtain the wound culture, and notify the primary care physician.

On 01/29/25 at 11:29 AM, V11 Wound Doctor said, R73 had a wound infection. I coordinate with the Infection Control Nurse and the Primary Doctor. The Infection Control Nurse ensures the order goes through appropriately and follows up on the wound culture results.

On 01/29/25 at 12:54 PM, V2 DON said, the facility's Infection Control Nurse left in August of 2024. I have had a few different Wound Nurses off and on over the past year. My current Wound Nurse started 3 days ago.

The Facility's Nursing Skin Integrity policy dated 03/20/23 shows, the licensed nurse using the EMR -electronic medical record observation tool, is to complete a Head-To-Toe Assessment to identify any/all areas of loss of skin integrity. The includes pressure injuries, non-pressure injuries, skin tears, bruises ...

Notify sites the wound nurse/DON of any skin integrity issues. Evaluate areas of loss of skin integrity and complete a wound consult as appropriate. If the wound doctor is following the resident's wound, their weekly assessment is sufficient for the week. It is the wound nurse/DON's responsibility to ensure all orders and/or recommendations from the Wound Physician are carried out timely.

On 01/28/25 at 11:11 AM, V2 DON-Director of Nursing removed R73 right pressure reduction

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boot. R73 had a 1 centimeter by 1 centimeter black/purple area on the bony prominence of the medial ball of his right foot that looked like a deep tissue injury.

On 01/28/25 at 11:11 AM, V2 DON said, the discoloration to the right medial ball of his right foot was not there last week when I assessed R73 with the wound doctor.

On 01/28/25 at 11:11 AM, R73 denied any injury to the foot.

On 01/28/25 01:49 PM, V2 DON, said, "I have not documented on R73's discoloration. None of the staff reported the discoloration. R73 has no record of recent injury. The wound doctor will see R73 tomorrow. I will call it discoloration and allow the Wound Doctor to make the determination."

On 01/29/25 at 9:43 AM, V10 Wound Doctor said, the wound on the right medial ball of R73's foot is a deep tissue injury. Deep tissue injuries are caused from the tissue resting against a surface for too long. R73 also has a diagnosis of diabetes which increases his risk for wound development. "I will classify the wound as a pressure ulcer."

The Facility's Nursing Skin Integrity policy dated 03/20/23 shows, evaluate areas of loss of skin integrity and complete a wound consult as appropriate. Complete the appropriate entry on the wound care log.

2. R45 Predicting Pressure Ulcer score risk dated 05/21/24 (admission) shows, "At Risk"

On 01/27/25 at 10:00 AM, R45 observed lying on her back.

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S9999	Continued From page 7 On 01/28/25 at 1:48 PM, R45 observed lying on back, the positioning wedge was sitting on a chair in her room. On 01/29/25 at 9:55 AM, R45 observed laying on her back with the head of the bed up at 45 degrees. On 01/29/25 at 10:08 AM, V10 Wound Care Doctor said, R45's wound was acquired in the facility. It currently measures 1.8 cm (centimeters) x 1.4 cm x 0.2 cm deep. On 01/29/25 11:02 AM, V2 said, on 5/14/24, R45 was Care Planned that she prefers to lay on her back, identified on admission. On 09/07/24 it was observed that R45 had an open area to her coccyx, we added the pressure reducing mattress that day (09/07/24). On 01/29/25 at 11:29 AM, V11 Wound Doctor said, it is not normal for skin to progress from intact tissue to a stage 4 pressure ulcer, it can happen. Skin can break down quickly and then the muscle. Perhaps the air mattress would have prevented the opening of the wound. R45's Admission Skin Observation Tool dated 05/14/24 shows, "Skin is intact ...". R45's Care Plan initiated 05/14/24 shows, R45 likes to lay on her back that can further increase risk of skin breakdown. Care Plan Initiated 05/21/24 R45 is in need of assistance with ADL's-Activities of Daily Living. She insists to stay in bed and needs staff encouragement and substantial maximal assist from staff to roll left and right. R45's Initial Wound Assessment by V11 Wound	S9999		

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Care Doctor dated 09/11/2024 shows, Stage 4 Pressure Wound Sacrum Full Thickness, Etiology Pressure, Duration greater than 4 days, Wound Size 3.5 cm x 2.6 cm x 0.4 cm.

The facility's Nursing Skin Integrity policy dated 03/20/23 shows, validate a care plan with appropriate interventions initiated.

R45's Physician's Orders dated 09/07/24 shows, R45's Pressure Redistribution Mattress was ordered 09/07/24.

The facility did not provide R45 with a pressure reducing mattress until after she developed a Stage 4 pressure ulcer.

3. R135's face sheets shows he has diagnosis including respiratory failure, dehydration, emphysema, urine retention, and protein calorie malnutrition.

On 1/27/25 at 9:43 AM, R135 was observed lying in bed. V8 (Certified Nursing Assistant-CNA) provided incontinence care. V8 removed his incontinent brief, his sacrum was red with an open area without a protective dressing in place.

On 1/28/25 at 10:44 AM, V2 (DON) went to provide wound care to R135. V2 removed his incontinent brief R135's sacrum remained without a dressing in place, his sacrum was red with an open area. V2 said R135 has a pressure ulcer to his sacrum and should have a dressing in place.

R135's Admission Evaluation dated 1/21/25 documents an open area to his buttock measuring 0.8 cm (centimeters) x .5 cm.

R135's Physician Order Sheets dated January

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S9999	Continued From page 9 2025 shows orders including sacrum open area-cleanse with normal saline dry and cover with a foam dressing daily. 4. On 01/27/25 at 01:15 PM, R35 observed in bed. There was an air mattress pump hanging on the foot of the bed. The power switch to the air mattress pump was in the off position. The green power button was not lit up. On 01/28/25 at 08:54 AM, V3 (Registered Nurse) confirmed the air mattress pump on R35's bed was off. V3 added that the pump should be on while R35 was in bed. R35's Order Summary Report printed on 1/28/25 showed an order for an air mattress. R35's Care Plan with an initiated date of 9/11/24 showed R35 was at risk for developing pressure injuries. Listed under interventions was for R35 to receive a pressure relieving/reducing mattress. On 01/28/25 at 01:39 PM, V4 (Certified Nursing Assistant) said an air mattress/pump is a pressure relieving intervention. (B)	S9999		