STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145602	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village at Victory Lakes, The	1055 East Grand Avenue Lindenhurst, IL 60046

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review the facility failed to ensure a resident (R1) was transported safely in a shower chair. This failure resulted in R1 sustaining a bimalleolar fracture of the right ankle. This affects 1 of 3 residents (R1) reviewed for accidents in the sample of 3. This past non-compliance occurred from 2/11/26 to 2/19/26. The findings include:R1's Facesheet shows R1 has diagnoses that include, but are not limited to: osteoarthritis of the right and left shoulders, atherosclerotic heart disease, history of poliomyelitis, dementia, and chronic kidney disease stage three. R1's Brief Interview for Mental Status dated 2/6/26 shows R1 is cognitively intact.On 2/23/26 at 9:08 AM, R1 had two wheelchair footrests with R1's name written on it. One footrest was on the seat of the wheelchair and the other was in a bag attached to the back of the wheelchair. R1 was lying in bed with a green cast on R1's right ankle that went up to the top of R1's right calf. R1 was not exhibiting any signs of pain. R1 said on the morning of 2/11/26, V3 (Certified Nursing Assistant- CNA) woke R1 up to provide R1 with a morning shower. R1 said V3 put R1 into a chair without footrests and as V3 started to move the chair and bring R1 to the shower room, R1's foot slipped off due to no footrests but doesn't recall exactly what happened. R1 recalls screaming out in pain and R1's right foot getting injured. On 2/23/26 at 9:46 AM, V3 said on 2/11/26 around 7:35 AM, V3 and V6 (CNA) got R1 up from bed to use the toilet. After using the toilet, V3 and V6 transferred R1 from the toilet to a shower chair that did not have footrests. After V3 took approximately two steps, while still in R1's room, R1 cried out in pain and said R1's right foot hurt. V3 immediately stopped pushing R1 in the shower chair and stated R1's right foot had caught on the ground and rolled under the chair as V3 pushed the chair forward. V3 notified V4 (Registered Nurse- RN) of the incident and V3 put R1 back into bed. R1 was provided an as needed pain medication and an ice pack. V3 cared for R1 the remainder of the day shift on 2/11/26 and said R1 did not want to leave R1's bed. V3 also cared for R1 on 2/12/26 on the day shift and stated R1 did not complain of pain throughout the duration of V3's shift, but R1 again did not want to leave R1's bed. On 2/23/26 at 11:00 AM, V4 said during the initial assessment of R1 after the incident, V4 did not see any swelling or bruising. V4 then notified V10 (Nurse Practitioner) who came and assessed R1. V4 said V10 provided orders to leave R1 in bed, place R1 on non-weight bearing status of the right leg, and to obtain an x-ray. V4 called to obtain an x-ray, which was completed on 2/11/26. On 2/23/26 at 11:16 AM, V9 (Licensed Practical Nurse- LPN) said V4 provided V9 with report at shift change of R1's injury and that an x-ray was going to be completed. V9 said when the results came back from the x-ray company between 10:15 PM and 10:30 PM. V9 notified V10 of the initial results showing there was no fracture. V9 said R1 had no complaints of pain during the evening shift on both 2/11/26 and 2/12/26.R1's Weights and Vitals Summary dated 2/23/26 shows R1 exhibited no pain from 2/11/26 at 2:00 PM until 2/13/26 at 10:39 AM. On 2/23/26 at 10:28 AM, V5 (LPN) said on 2/13/26, V5 was notified by staff that R1 was expressing excruciating pain. V5 provided R1 with as needed pain medication and immediately notified V10 who (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145602	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/23/2026
NAME OF PROVIDER OR SUPPLIER Village at Victory Lakes, The		STREET ADDRESS, CITY, STATE, ZIP CODE 1055 East Grand Avenue Lindenhurst, IL 60046	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	was already enroute to the facility to complete rounds. V10 gave V5 orders to obtain a stat (immediate) x-ray for R1's right ankle. R1's x-ray results from 2/13/26 shows R1 had minimally displaced acute or subacute fractures of the medial [inner] and lateral [outer] malleoli [ankle bones].On 2/23/26 at 12:17 PM, V10 said on 2/13/26, R1 was expressing excruciating pain in R1's right ankle upon an in-person assessment, after the stat x-ray was completed. V10 ordered staff to send R1 to the emergency room before receiving the results of the x-ray. V10 said R1's age and bone mineral density could have been contributing factors to R1's fracture, but R1's foot getting caught on the floor and rolling under the chair could have been a direct cause of R1's ankle fracture.On 2/23/26 at 12:06 PM, V2 (Assistant Director of Nursing- ADON) said prior to the incident, the procedure of transporting residents to the shower room was to bring a shower chair to the resident's room, disrobe the resident, transfer them to the shower chair, and then wheel the shower chair from the resident's room to the shower room. However, V2 said after the 2/11/26 incident with R1, the facility changed the procedure for residents that utilize footrests. V2 said staff will now use a wheelchair with footrests to bring the resident to the shower room, where staff will transfer the resident from the wheelchair to a shower chair, provide the resident with a shower, place the resident back into their wheelchair when finished with the shower, and take the resident back to their bedroom. Facility provided in-service sign-in sheet dated 2/2026 shows nursing staff were educated on Shower chair use- Shower chairs without foot support are to only be used within the shower room.On 2/23/26 at 1:38 PM, V1 (Administrator) and V11 (Executive Director) said nursing staff had already changed the procedure and began in-servicing staff on 2/14/26. During the weekly weights, falls, and wounds meeting on 12/19/26, the interdisciplinary team gathered and discussed R1's incident and conducted a condensed quality assurance meeting. V1 said staff are actively conducting weekly audits to ensure staff compliance with the updated procedure. V1 said there were no similar accidents prior to R1's 2/11/26 incident and there have been no additional accidents since the procedure change. Prior to the survey date of 2/23/26, the facility had taken the following actions to correct the noncompliance:1. On 2/14/26, the facility updated their shower transfer procedure and identified all residents that are affected.2. On 2/14/26, the facility began in-servicing V3 and the rest of the nursing staff on the updated shower transfer procedure. The facility has also developed a system to ensure all employees not yet in-serviced will receive the in-service information prior to the start of their next shift at the facility.3. On 2/19/26, the facility conducted a quality assurance meeting to discuss the incident, the updated procedure, and to devise ongoing auditing to ensure compliance with the new procedure by nursing staff.