STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146178	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Victorian Village Hlth & Well	12525 W Renaissance Circle Homer Glen, IL 60491

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and procedure regarding privacy and confidentiality of health information. This applies to 2 of the 3 residents (R2, R3) reviewed for privacy/confidentiality in the sample of 5. The findings include: 1. The electronic medical record (EMR) shows R2 is 77 years-old who was admitted to the facility for a short-term rehab and was discharge from the facility on May 23, 2025. R1 was discharge with multiple medications including the Fluticasone furoate-vilanterol (Breo Ellipta) inhaler. However, on May 22, 2025 (the day prior to R2's discharge), R2's (inhaler) was sent with R1 when R1 was discharge that day. On June 2, 2025, at 8:58 AM, V15 (R1's Daughter) stated that she picked up R1 from the facility and brought him home with her. V15 found R2's Breo Ellipta inhaler when she started sorting through R1's medications that was provided by the facility. V15 called the facility to inform them about it. 2. The EMR shows R3 is 77 years-old who was admitted to the facility on [DATE], for a short-term rehab. Physician ordered multiple treatment including occupational therapy. R3 remained in the facility at the time of this survey. On June 2, 2025, at 8:58 AM, V15 said that V12 (Home Health Physical Therapist/PT) went to their house to evaluate R1. During evaluation, V12 asked a question that was not related to R1's condition. Upon review of R1's electronic medical records, V12 found a page of R3's therapy notes. V15 also verbalized concern, that information of other residents (R2's medication and R3's therapy note) was sent to them. On June 2, 2025, at 2:58 PM, V12 (Physical Therapist/PT) stated that she saw R1 for initial physical therapy (PT) assessment. V12 obtained R1's information from the electronic medical records (EMR) of their agency which was provided by the nursing facility where R1 came from. There was multiple information in the EMR including laboratory results, medications and therapy notes. However, V12 did not notice the discrepancy until she assessed R1 and interviewed V15 (R1's daughter). V12 inquired about R1's arm sling. V12 was informed that R1 does not wear a sling. V12 reviewed R1's EMR again and realized that the page of the medical record that she was reading belonged to R3. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146178	A. Building B. Wing	06/05/2025

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Victorian Village Hlth & Well	12525 W Renaissance Circle Homer Glen, IL 60491

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility presented a copy of R1's discharge medical record that was sent to the home health agency. The discharge documents show multiple information including therapy notes. There was a page in R1's therapy notes that belongs to R3. It was an occupational therapy note dated May 21, 2025, which showed R3's name, birthday, and plan of care. On June 2, 2025, at 2:34 PM, V1 (Administrator) stated V15 called the facility and reported that R1 did not received the Metoprolol medication prescribed to him. When V1 delivered the Metoprolol, V15 informed her that R3's inhaler was sent with R1. V15 returned the inhaler to V1. On June 3, 2025, at 1:29 PM, V1 also stated that part of the discharge referral for home health care is to send information or medical records of the resident to the home health provider. The expectation is to release accurate documentations/documents to the provider; the documents should only pertain about the concerned resident. The facility's Confidentiality of Health Information/HIPAA policy and procedure with the most recent review date of December 2023, shows: Policy: The facility will uphold the client's right to have their health information kept confidential. Procedure: The medical records department will establish systems that ensure that client information is maintained in an orderly and secure manner. Establish systems will cover areas including but not limited to record storage, records maintenance, and record release. Facility's Notice of Privacy Practices (undated) shows: Facility is required by law to maintain the privacy of your protected health information (PHI) and to provide you with a notice of its legal duties and privacy practices. State and federal laws require this facility to maintain the privacy of your health information .

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, and record review, the facility failed to ensure that all prescribed medication was provided to the resident upon discharge. This applies to 1 of 3 residents (R1) reviewed for discharge process in the sample of 5. The findings include: The electronic medical record showed that R1 is 93 years-old who was admitted to the facility for a short-term rehab, and was discharged from the facility on May 22, 2025, to his daughter's (V15's) home. R1's discharge order summary report showed multiple prescribed medications, including Metoprolol Succinate ER 12.5 milligrams (mg) twice a day. On June 2, 2025, at 8:58 AM, V15 (R1's Daughter) said she sorted through R1's medications when they got home, and observed that the prescribed medication, Metoprolol, was missing. However, V15 found a Breo Ellipta medication that belongs to R2, that was mixed among R1's discharge medications. On June 3, 2024, at 12:53 PM, V9 (Nurse) stated that part of their discharge process is to ensure that prescribed medications were reviewed, and dispensed medications were provided to the resident either for 15 days or 30 days, depending on the request of the resident or resident representative. They also review and itemize each medication with the resident or resident representative prior to discharge to ensure that they are going home with the right medications and prescriptions. On June 2, 2025, at 2:34 PM, V1 (Administrator) stated V15 called the facility and reported that R1 did not received the Metoprolol medication prescribed to him. V1 delivered the Metoprolol to R1 on May 23, 2025. On June 4, 2025, at 12:11 PM, V2 (Director of Nursing/DON) stated that it is their expectation upon the resident's discharge that the nurse will give discharge instructions, including medication review to the resident and family; ensuring that resident will be discharged with the medications that were prescribed to them. Facility's policy and procedure for Discharge of a Client with the review date of May 2024, shows multiple procedures including: - Complete client/family education about treatments, procedures, and supply use and document in the medical record. - Review medications and use with responsible party. - Arrange for medication needs at home.