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	03/26/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the transfer method recommended by physical therapy and indicated in the resident's plan of care. This failure resulted in R1 sustaining a 12cm (centimeter) left lower leg laceration, transfer to the hospital, and laceration repair with 21 sutures.This applies to 1 resident (R1) reviewed for safe transfers in a sample of 4.The findings include:On 3/24/2026 at 1:24 PM, R1 was in bed with a gauze wrap on her left leg.On 3/24/26 at 4:07 PM, V5 (CNA/Certified Nurse Assistant) said on 3/4/26 V12 (CNA) asked her to assist with transferring R1. V5 said prior to the transfer, R1's wheelchair was next to her bed, facing the head of the bed, with R1's left leg next to the bed. V5 said she was standing behind R1's wheelchair, and did not touch R1 during the transfer. V5 said V12 told R1 to hold onto the bed rail with her left hand while V12 put her arms under R1's armpits while she stood up. V5 said V12 did not use a gait belt or sit to stand mechanical lift. V5 said R1 stood up, pivoted to her left and sat down on the bed and then said my leg. V5 said she and V12 then looked down and saw R1's leg was bleeding and V5 thought R1 must have scraped her leg on the wheelchair during the transfer. V5 said she never took care of R1 before and she did not know R1's transfer status, she trusted V12 knew how to transfer R1 safely. V5 said the CNAs have to follow the transfer status recommended by therapy, because they are the ones who evaluate the resident for safe transfer and that is their expertise.On 3/24/26 at 10:48 AM V2 (DON/Director of Nursing) said on 3/4/26 as V5 and V12 (CNAs) were transferring R1 from her wheelchair to her bed, R1's leg got caught on the wheelchair and once she was in bed, the CNAs noticed the laceration on her left leg. V2 said at the time of the transfer, R1 was a sit to stand mechanical lift transfer as per physical therapy assessment and recommendation. V2 said as a result of R1's injury during transfer, V12 no longer worked at the facility and had been let go due to improper transfer and not following the facility culture of safety.On 3/25/26 at 9:27 AM, V13 (PTA/Physical Therapy Assistant) said as of 3/4/26, the nursing staff was expected to transfer R1 with the sit to stand mechanical lift with 2 staff assistance. V13 said there were times in the therapy gym that R1 was able to transfer with max assist x1 therapist with gait belt, but therapy delegated to the nursing staff to use the sit to stand mechanical lift with 2 staff for transfers. V13 said therapy would have to observe R1 perform repeated max assist stand and pivots in the therapy gym before they would upgrade R1's transfer status to a one-person max assist. V13 said therapy always encourages gait belts to be used for max assist transfers so there is a place for staff to hold other than the resident's appendage. V13 said lifting from under a resident's armpit puts them at greater risk for injury.R1's Face Sheet shows she was admitted to the facility on [DATE] with primary diagnosis of disorder of muscle and R1's POS (Physician Order Sheet) shows an order dated 2/26/26 may have physical therapy evaluate and treat as indicated.R1's Transfer to Hospital Summary dated 3/4/26 at 23:35 stats RN (registered nurse) was notified by CNA that assistance was needed in the resident's room. Upon entering, resident was observed sitting on the edge of the bed with an open laceration noted to the left lower leg with active bleeding present. When asked about the incident, CNA reported resident obtained skin injury during transfer. Assessment revealed a laceration (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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	measuring approximately 13cm in length and 3cm in width to the left lower leg. Due to the size and depth of the wound, RN activated EMS (911) for transfer to the hospital for further evaluation and treatment. Resident transported via EMS for further evaluationR1's ED (Emergency Department) Provider Notes dated 3/4/26-3/5/26 shows: Laceration Repair on 3/5/26 at 4:46 AM of left lower leg 12cm length and 5mm (millimeter) depth laceration with 21 simple interrupted sutures.R1's Care Plan initiated 2/26/26 states resident has an ADL self-care performance deficit related to deconditioning and interventions include transfer resident with sit to stand machine.The facility's policy titled, Lifts and Safe Client Movement Program last revised 1/26 states, Policy:.committed to providing safe care that maximizes clients' quality of life while maintaining a safe work environment for employees. The Safe Client Movement Program includes client movement equipment, employee training, client plan of care and a culture of safety approach to safety in the work environment. Definitions:. Client Movement Equipment: Equipment used to assist in the lift, transfer or repositioning process. Examples include gait belts, sit to stand lift, total mechanical lift, sliding boards, repositioning sheets, etc. Employee Responsibilities:.It is the responsibility of the employee to follow the transfer method indicated in the plan of care.