

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Victorian Village Hlth & Well		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>45906</p> <p>Based on observation, interview and record review the facility failed to follow manufacturer guidelines for blood glucose monitoring.</p> <p>This applies to one resident (R35) reviewed for quality of care in a sample of 19.</p> <p>Findings include:</p> <p>R35's Face sheet shows a diagnosis of type 2 Diabetes Mellitus. R35's POS (Physician Order Sheet) shows an order dated 8/27/24 to check blood glucose twice a day. R35's Weights and Vitals Summary shows his blood glucose result on 9/10/24 at 9:34 AM was 72, and his blood glucose result on 9/12/24 at 8:00 AM was 88.</p> <p>On 9/11/24 at 8:11 AM, V18 (RN/Registered Nurse) was observed checking the blood glucose of R35. V18 first cleaned R35's finger with an alcohol wipe, then waved his gloved hand at the finger to dry the alcohol. V18 then poked R35's finger with lancet, squeezed out a drop of blood, wiped it with alcohol wipe, squeezed out a second drop of blood, and then placed that drop on testing strip to obtain blood glucose. The alcohol had not had enough time to dry from resident's finger after V18 wiped the first drop of blood off and placed the second drop on test strip. V18 told R35 that his blood glucose result was 153 and R35 replied, Oh, that is high for me, I am usually low 100s.</p> <p>On 9/12/24 at 2:51 PM, V2 (DON) said the nurse is supposed to allow the alcohol time to dry on the resident's finger before placing blood sample on testing strip, because the alcohol on the skin can affect the blood sugar reading and give an inaccurate blood glucose result.</p> <p>R35's Care Plan initiated on 9/10/24 shows the resident has Diabetes Mellitus and interventions include obtain fasting serum blood glucose as ordered by the doctor.</p> <p>The facility's policy titled, Blood Glucose Monitoring last reviewed 1/24 states, Procedures: .6. Obtain sampling of blood. Follow manufacturer's instruction for use of glucometer . *MANUFACTURER GUIDELINES: 1. Allow finger to dry after swabbing with alcohol .</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, & record review, the facility failed to provide ADL care (activities of daily living) to dependent residents. This applies to 3 of 4 residents (R24, R27, & R30) reviewed for ADL care in a sample of 19.</p> <p>Findings include:</p> <p>1. On 09/10/24 at 11:28 AM, R24 was observed in the dining room during activities, and she was observed scratching her head. At 12:26 PM, R24 was observed again but while she was being toileted and receiving incontinence care and R24 was still scratching her head and white flakes were observed on her shirt. At 01:09 PM, R24 was observed scratching her head and her nails were observed jagged with brown substance under the nails. R24's hair was observed dry with no oil present. R24 said that her head itches.</p> <p>R24's electronic health records showed that R24 is an [AGE] year old female admitted to the facility on [DATE] with diagnoses including encounter for palliative care, major depressive disorder, anxiety disorder & hypertension. R24's 8/19/24 MDS (Minimum Data Set) showed that R24 is dependent for personal hygiene. R24's 8/29/24 care plan showed that R24 has an ADL self-care performance deficit related to diagnoses including dementia with interventions including personal hygiene needing dependent assistance.</p> <p>2. On 09/10/24 at 12:02 PM, R27 was in her room with V15 (R27's daughter) present. V15 said that she has a problem with the staff not taking care of her mother's dry skin. R27 was observed with dry skin on her arms and legs.</p> <p>R27's electronic health records showed that R27 is an [AGE] year old female admitted to the facility on [DATE] with diagnoses including unspecified dementia, hypertension, anxiety disorder & depression. R27's MDS showed that R27 needs dependent care for personal hygiene. R27's 9/13/22 care plan showed that she has an ADL self-care performance deficit related to deconditioning, and diagnoses including dementia with interventions including personal hygiene needing substantial/maximal assistance.</p> <p>3. On 09/10/24 at 02:06 PM, R30 was observed in her bed with her fingernails on her right hand polished red and no polish on her fingernails on her left hand. On R30's left thumb a reddish brown colored substance was observed on the thumb and under the thumbnail. R30's right and left hands fingernails were also observed with long jagged nails with brown substances under the nails. At 02:12 PM V5 (Nurse) was told about the reddish brown substance on R30's thumb and came to examine R30. After examining R30 V5 left the room and then returned to clean R30's thumb and told the state surveyor that the staff informed him that the reddish substance on R30's thumb was strawberry jelly. At 02:17 PM, V8 CNA (Certified Nurse's Assistant) said that R30 had strawberry jelly and toast for breakfast and watermelon for lunch and that R30 eats with her hands and that was probably what was on her thumb. At 02:21 PM, V5 came out of R30's room after washing her hands and said that the reddish brown substance was the strawberry jelly and probably the watermelon too.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R30's electronic health records showed that R30 is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including hemiplegia & hemiparesis, spastic hemiplegia affecting right dominant side, dementia adjustment disorder, osteoporosis, depression and anxiety disorder. R30's 12/26/23 care plan showed that R30 has an ADL self-care performance deficit related to deconditioning, and diagnoses including right hemiparesis from previous CVA (cerebral vascular accident). The interventions included personal hygiene - dependent, shower bathe - substantial/maximal assist, check nail length and trim and clean on bath day and as necessary. R30 7/6/24 MDS showed - eating supervision or touch assistance, personal hygiene - dependent and R30's 7/7/24 mental cognition is moderately impaired.</p> <p>On 09/12/24 at 11:53 AM, V1 (Administrator) said that nails should be short and non-jagged, and they should be clean for hygiene, infection control, and dignity. V1 said that the resident's skin should be moisturized because the residents have poor skin elasticity, and to prevent skin tears.</p> <p>The facility's Activities of Daily Living (ADL) Care policy (2/5/24) showed ADL care is provided to prepare the client for daily activities, promote good health, hygiene and well-being. Based on the needs of resident, ADL care may be comprised of skin care, nail care, toilet assist-incontinence care and personal hygiene.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>45906</p> <p>Based on observation, interview, and record review, the facility failed to maintain indwelling urinary catheter according to best practice to prevent complications.</p> <p>This applies to 1 resident (R151) reviewed for urinary catheter in a sample of 19.</p> <p>The findings include:</p> <p>R151's Face sheet shows a diagnosis of chronic kidney disease. R151's MDS (Minimum Data Set) dated 8/21/24 shows her cognition is intact. R151's Care Plan revised on 9/10/24 shows the indwelling urinary catheter is to be reinserted due to urinary retention. Interventions include position the catheter bag and tubing below the level of the bladder and away from entrance room door.</p> <p>On 9/10/24 at 12:16 PM, R151 said my bladder is not working again, they are going to put a catheter in again. On 9/11/24 at 2:11 PM, R151 said they put my catheter back in again late yesterday afternoon. Surveyor then noticed while R151 was lying in bed, the urinary catheter drainage bag was not hooked to the bed frame or seen on either side of R151's bed. On 9/11/24 at 2:16 PM, surveyor noted that R151 was lying in bed and was wearing a urinary catheter leg bag on her left leg. R151 was wearing pants and the urinary catheter tubing and leg bag was on her leg, even with her bladder. The urine in R151's leg bag was minimal. R151 said the nurse had not emptied the urine in the leg bag in a long while and she was having some lower abdomen discomfort.</p> <p>On 9/11/24 at 2:20 PM, V16 (RN/Registered Nurse) said R151 had an indwelling urinary catheter placed yesterday because she was retaining urine. V16 said R151 should not have a leg bag on while she is lying in bed because the urine can back flow into the bladder and cause a urinary tract infection (UTI). On 9/12/24 at 11:31 PM, V2 (DON/Director of Nursing) said a resident should not be lying in bed with an indwelling catheter leg bag on. V2 said the CNA (Certified Nurse Assistant) should have communicated to R151's nurse when R151 was assisted back into bed so the nurse could have switched the leg bag to a regular catheter drainage bag. V2 said the leg bag while in bed can cause urinary reflux from the tubing back into the bladder which can cause a urinary tract infection. V2 said the tubing and drainage bag of the urinary catheter should be lower than the bladder at all times to prevent UTI.</p> <p>On 9/12/24 at 1:44 PM, V2 said the facility does not have a policy regarding indwelling catheter maintenance. The facility's policy titled, Catheter Insertion, Removal, and Changing last reviewed 12/23 states, Policy: Catheters are utilized and maintained according to best practice. Indwelling catheters are utilized for the following purposes: 1. Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible .14. Secure urinary drainage bag below the level of the bladder .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>45906</p> <p>Based on observation, interview, and record review, the facility failed to follow physician medication orders.</p> <p>This applies to one resident (R146) reviewed for quality of care in a sample of 19.</p> <p>Findings include:</p> <p>On 9/10/24 at 11:47 AM, R146 said her pain was getting up to an 8 (on a scale of 0-10) and she was just about to call the nurse to ask for a hydrocodone/acetaminophen pain pill. R146 said it had been about 4 hours since she last took pain medication and every 4 hours the pain starts to creep up again. R146's Face sheet shows diagnoses of history of falling and contusion of left lower leg. R146's POS (Physician Order Sheet) shows two orders for hydrocodone-acetaminophen PRN (as needed) pain medication. The first order shows hydrocodone-acetaminophen oral tablet 5-325mg (milligram) give 1 tablet by mouth every 4 hours as needed for moderate to severe pain *DO NOT EXCEED 3 GM (gram)/DAY ACETAMINOPHEN FROM ALL SOURCES*. The second order shows hydrocodone-acetaminophen oral tablet 5-325mg give 2 tablets by mouth every 4 hours as needed for moderate to severe pain *DO NOT EXCEED 3 GM/DAY ACETAMINOPHEN FROM ALL SOURCES*. R146's eMAR (electronic medication administration record) shows R146 received a total of 11 tablets of hydrocodone-acetaminophen 5-325 mgs on 9/11/24. This equals a total of 3,575 milligrams of acetaminophen or 3.575 grams of acetaminophen, which exceeds the maximum 3 gram 24 hour limit written in the physician's order.</p> <p>On 9/12/24 at 11:31 AM, V2 (DON/Director of Nursing) verified that R146 was administered 11 tabs of hydrocodone/acetaminophen 5-325 mgs on 9/11/24. V2 said 11 tabs equates to 3.575 grams of acetaminophen which exceeds the physician's order of 3 grams maximum in a day. V2 said the harm in administering more than 3 grams of acetaminophen in a day is kidney and liver toxicity and/or damage for the resident.</p> <p>On 9/12/24 at 2:51 PM, V2 said the facility did not have a policy that pertains to following physician orders.</p> <p>R146's Care Plan initiated on 9/9/24 states the resident has a risk for pain and interventions include: administer as needed hydrocodone/acetaminophen as per the physician's orders.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003</p> <p>Based on observation, interview and record review the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness.</p> <p>This applies to all 46 residents in the facility receiving dietary services.</p> <p>Findings include:</p> <p>On [DATE] at 3:42 PM V2 DON (Director of Nursing) confirmed on [DATE] all 46 residents of the facility received dietary services.</p> <p>On [DATE] at 10:08 AM, the facility main kitchen was toured with V9 Director of Dining Services.</p> <p>Dust was covering the vents over the stove. Open pots of food were cooking on the stove.</p> <p>Large Refrigerator-</p> <p>Zipped bag of 3 hot dogs dated [DATE].</p> <p>Ham loosely wrapped with plastic wrap open and exposed dated [DATE].</p> <p>Raw ground beef 10lb chub open end covered by plastic wrap meat gray. No opened on or use by date.</p> <p>Shredded Mozzarella cheese 5lb (pound) dated ,d+[DATE] bag open to air no use by date.</p> <p>Grated parmesan cheese 5lb opened dated [DATE].</p> <p>Yellow sliced cheese no labels no open on or use by dated. Corner of cheese hard.</p> <p>Grated parmesan 5lb bag open dated ,d+[DATE] and ,d+[DATE]. V9 stated it has too many dates and not sure when it expires.</p> <p>Vanilla icing 12lb opened with brown specs in it no opened on or use by dates.</p> <p>Blue bucket with no product label delivery date or use by date contained sliced brown mushrooms with dark spots on them.</p> <p>Pantry-</p> <p>V9 Director of Dining Services stated we throw dented cans out we don't send them back anymore.</p> <p>Dented cans:</p> <p>Two cans of pinto beans 6lb (pounds) 15oz (ounces).</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Diced tomatoes 6lb 5oz</p> <p>Two cans of water chestnuts 3lb 14 oz</p> <p>Pumpkin pie mix 30 oz.</p> <p>Two cans chunk tuna</p> <p>White flakes identified by V9 as coconut [NAME] wrapped in plastic writing not legible.</p> <p>Freezer 1-</p> <p>items identified by V9 that were in a clear plastic bag and did not have a manufacture label or facility label with contents, dates: chicken cordon blue, omelets with frost in the bag, sweet potato fries, two bags of hash browns.</p> <p>Zipped bag dated ,d+[DATE] identified by V9 as lamb meat.</p> <p>Box of sliced beef 42 oz manufactures expiration date of [DATE]</p> <p>Cookie dough pieces 20lb box plastic bag open with frost and freezer burn.</p> <p>V9 stated everything should have a label and dates written on it so we know what it is when it came in, when it is opened and when it expires.</p> <p>Cabinets 7.5L (Liter) storage containers with cereals bran with raisins, oat o's, flakes of corn, crisped rice all with expiration date of [DATE].</p> <p>White powder in 6L container identified by V9 as flour no label or date.</p> <p>Dried pasta 2lb box opened with contents exposed.</p> <p>Freezer 2-</p> <p>Items identified by V9.</p> <p>Two clear plastic bags with French fries - no label or dates.</p> <p>Seasoned curly fries bag opened no label or dates.</p> <p>Stuffed shells dated ,d+[DATE] with freezer burn and frost in the bag.</p> <p>Cookie dough in bag exposed to air with no label or dates.</p> <p>Bagged Waffles no labels or dates.</p> <p>Bagged French toast sticks no labels or dates.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Kitchen Drawers-</p> <p>Drawer with kitchen utensils crusty with dried spills and crumbs.</p> <p>Drawer with jelly roll pans crusty</p> <p>Drawer with skillets - skillets were coated with grease.</p> <p>Drawer with hand grater was dirty with fingerprints and smeared with a dried substance.</p> <p>On [DATE] at 1:42 PM the second-floor kitchenette was toured with V11 CNA (Certified Nursing Assistant)</p> <p>Cabinets-</p> <p>Items stored under the kitchen sink two red buckets, plastic bags, dishwasher powdered detergent 75 oz box, liquid cleanser 2lb 8oz and pan cleanser 2.5L.</p> <p>Upper cabinet- bag of 1lb potato chips opened exposed to air dated ,d+[DATE].</p> <p>Bag of potato chips no opened on or use by date.</p> <p>Refrigerator-</p> <p>Clear bowl of peaches in juice loosely covered with plastic wrap no label or dates.</p> <p>Clear bowl of cantaloupe and watermelon loosely covered with plastic wrap no dates or label.</p> <p>Sliced yellow cheese poorly wrapped in plastic corner of cheese dried out no label or use by date.</p> <p>Freezer-</p> <p>Chocolate shakes from three different fast-food restaurants with open tops no labels to identify who they belong to. Only one shake had a sticker from the restaurant dated [DATE].</p> <p>On [DATE] at 10:19 AM, Faith house kitchen was observed with V13 CNA.</p> <p>Refrigerator-</p> <p>A clear bowl with mixed fruit did not have a label or date.</p> <p>Drawers-</p> <p>Drawer with muffing tin and jelly roll pans had dark splattered substance and crumbs in it.</p> <p>All the potholders in the drawer were dirty and crusty with food stains and particles.</p> <p>Two food warmers had dirty water in them and were caked with grease and dried drips of food.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Lower cabinet with ketchup had a large dried dark orange spill.</p> <p>On [DATE] at 1:09 PM, V9 Director of Dining Services stated it is important to label foods with delivery date, open date and expiration date to make sure we aren't serving expired foods. If we use food from dented cans, it can develop bacteria. If someone eats it, they could get sick. The kitchen should be cleaned daily. in the houses the CNAs are responsible for the kitchen cleaning. Nursing should be overseeing the little house but it all falls under me so I should be doing rounds and reporting it to the appropriate manager if it is not being done. The kitchen should be cleaned and sanitized daily and after each use. The water in the steamer stray / warmer should not be left in there. The CNAs should be cleaning the refrigerators out completing the logs. They should be labeling food with open on and use by dates as well. foods should be sealed to avoid bacteria and contamination. Nothing should be stored under the kitchen sink. Open food in the freezer will get freezer burn, contaminated and it affects the taste. If food is removed from the original container, it should be labeled with the name of the product, open on and use by dates.</p> <p>On [DATE] at 1:44 PM, V2 (DON) Director of Nursing, stated the CNAs are responsible to make sure the kitchenettes are clean and completing the logs. The nurses are responsible for making sure the CNAs are completing their tasks and keeping the kitchen is in order. V2 stated he is responsible for making sure the nurses are monitoring the CNAs.</p> <p>The facility did not provide the requested kitchen logs for the two small house or 2nd floor for the dishwasher, refrigerator/freezer. Sanitization bucket or breakfast holding temperatures.</p> <p>The facility policy Food Storage Expiration Dates dated [DATE] states all opened food that is placed into storage shall be labeled with the product name, date opened and or expiration or use by date. leftover food and leftover deli meats expire three days after opening. Dairy products not in the original container expires 3 days after opening. Thawed, uncooked frozen foods and raw meats expires seven days after opening.</p> <p>The facility policy Storage dated [DATE] states all food, chemicals and supplies should be stored in a manner that ensures quality and maximizes safety of the food served. Personal items are not to be store in food supply storage areas. Store food in its original container if it is clean, dry and intact. If necessary, repackage food in clean, well labeled containers using food storage label.</p> <p>The facility policy Machine Ware Washing- High Temperature dated [DATE] states the dish machine will be checked prior to each meal period to ensue that it is functioning properly. Employees who use the dish machine will be responsible for knowing how to use the machine, document its use and properly maintain it after use. Record the date/ temperature and initial the entry on the dish machine record form. This should be done one time per meal period. The dining services manager / designee will check the temperature monitoring form to ensure that temperatures and thermal sticks meet standards and are recorded daily.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384</p> <p>Based on observation, interview, & record review, the facility failed to provide proper hand hygiene during incontinence care & while providing a physical exam.</p> <p>This applies to 3 of 4 residents (R24, R96, & R16) reviewed for bowel and bladder incontinence, and 1 of 4 residents (R30) reviewed for ADL care (Activities of Daily Living) in a sample of 19.</p> <p>The findings include:</p> <p>1. On 09/10/24 at 12:48 PM, V3 CNA (Certified Nurse's Assistant) was observed toileting and providing incontinence care for R24. R24 was observed standing over the toilet and V3 was observed with gloved hands removing R24's soiled brief and then setting R24 on the toilet. V3 then was observed getting a tissue and cleaned R24's nose. V3 then removed her gloves and put on clean gloves but did not clean her hands. V3 then moved R24's (reclining high back) chair in her room, then returned to the bathroom, and removed her gloves and put on new gloves but did not clean her hands. V3 then grabbed a box of tissue and wiped R24's perineal area then wiped R24's buttocks cleaning stool from R24. V3 then removed her gloves and again did not clean her hands before putting on clean gloves and then applied barrier cream to R24's buttocks. V3 then touched R24's walker, put a clean brief on R24 and pulled up R24's pants with her dirty gloved hands. V3 then removed the dirty gloves but did not clean her hands and then touched R24's back and assisted R24 out of the bathroom, walked R24 to the recliner in her bedroom, removed the gait belt from around R24's waist, put a pillow behind R24's head, put R24's call light within reach, took a throw blanket off of R24's bed and placed it on R24, picked up the TV control and turn the TV on, and then pushed R24's reclining high back) Chair into R24's bathroom. V3 did all of this with her uncleaned hands.</p> <p>R24's 8/23/24 care plan showed that R24 has an ADL self-care performance deficit related to diagnoses including dementia, and impaired balance, with intervention including personal hygiene - dependent assistance, bowel incontinence - provide peri care after each incontinent episode. R24's 8/13/24 MDS (Minimum Data Set) showed that R24 has long and short term memory problems. R24's 8/19/24 MDS section GG showed that R24 is dependent on toileting and personal hygiene.</p> <p>2. On 09/11/24 at 09:58 AM, V4 (Wound Nurse) was providing incontinence care for R96 while R96 was in bed. V4 with gloved hands cleaned R96's perineal area, then picked up a clean brief with the same dirty gloved hands, rolled R96 to her right side, wiped R96's buttocks, removed the soiled brief, put the clean brief under R96, rolled R96 back on her back, and attached the clean brief on R96. V4 then put the wipes back in R96's drawer, adjusted the sheets on R96 and then V4 removed her gloves. Then V4, after removing her gloves, began touching personal items on R96's dresser and touching items used for R96's wound care treatment including the scissors. V4 did this with ungloved and uncleaned hands.</p> <p>On 09/11/24 at 10:12 AM, V4 said that she should have removed her gloves and cleaned her hands and then put on clean gloves after providing perineal care and going from a dirty area to clean area for infection control and to prevent cross contamination.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146178	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024
NAME OF PROVIDER OR SUPPLIER Victorian Village Hlth & Well		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R96's 7/23/24 care plan showed that R96 has occasional bladder incontinence with diagnoses including OAB (overactive bladder).</p> <p>3. On 09/10/24 at 02:06 PM, R30 was observed in her bed with her right hand fingernails polished red and no polish on her left hand fingernails. On R30's left thumb a reddish brown colored substance was observed on the thumb and under the thumbnail. At 02:12 PM, V5 (Nurse) was observed at the nurses' station typing at the computer when he was informed of R30's reddish colored thumb. V5 was observed getting up from the computer, coming into R30's room, and putting on gloves, but V5 did not clean his hands before putting on the gloves. V5 then began examining R30, touching her hands and other parts of her body including her face to determine the source of the reddish brown color on her thumb. V5 said that it was dry blood on R30's thumb but was unable to locate where R30 was bleeding from.</p> <p>R30's electronic health records showed that R30 is a [AGE] year old female admitted to the facility on [DATE] with diagnoses including hemiplegia & hemiparesis, spastic hemiplegia affecting right dominant side, dementia adjustment disorder, osteoporosis, depression and anxiety disorder. R30's 12/26/23 care plan showed that R30 has an ADL self-care performance deficit related to deconditioning, and diagnoses including right hemiparesis from previous CVA (cerebral vascular accident). The care plan interventions include personal hygiene - dependent, shower bathe - substantial/maximal assist, check nail length and trim and clean on bath day and as necessary. R30 7/6/24 MDS section GG personal hygiene - dependent. R30's 7/7/24 MDS section C showed that R30's mental cognition is moderately impaired.</p> <p>On 09/12/24 at 11:58 AM, V1 (Administrator) said that the staff should remove their gloves, clean their hands and put on new gloves after leaving a contaminated area or touching a contaminated item, and before going to a clean area or touching a clean item for infection control.</p> <p>The facility's Infection Control Nursing Procedures policy dated 1/4/2023 showed, Subject: Handwashing - handwashing is considered one of the most effective infection control measures. The policy showed under Frequency: After handling any contaminated items. Before and after having contact with a client's intact skin during client care. If hands will be moving from a contaminated body site to a clean body site during client care. Before and after using gloves.</p> <p>45906</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Victorian Village Hlth & Well		STREET ADDRESS, CITY, STATE, ZIP CODE 12525 W Renaissance Circle Homer Glen, IL 60491	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. On 9/11/24 at 10:10 AM, V17 (CNA/Certified Nurse Assistant) provided incontinence care for R16. First, V17 put gloves on, then she touched the bedside table, R16's nightstand drawer handle to remove wipes out of the drawer, then she touched the blinds to close them. With the same gloves on, V17 removed R16's sheet and blanket and put her heel boots back on. Next, with the same gloves on, V17 placed a new incontinence pad inside a new incontinence brief, touching the area that would be against R16's perineum. V17 then removed wipes and unfastened R16's incontinence brief and used the wipes to clean under R16's abdomen fold and her right and left groin. R16 then rolled to her left side and V17 wiped R16's buttocks. V17 then rolled the soiled incontinence brief under R16's left side and placed the clean brief under her buttocks. V17 then had R16 roll onto her right side and V17 removed the soiled incontinence brief from R16's left side and pulled the clean brief through. R16 then turned onto her back and V17 pulled the clean brief up through/between R16's legs and V17 fastened the brief. V17 did not change her gloves or perform hand hygiene once throughout this process while she touched possibly contaminated surfaces, then touched the resident and her soiled incontinent brief, and then touched the new/clean brief. V17 went from dirty/contaminated areas to clean areas while wearing the same gloves.</p> <p>On 9/12/24 at 11:31 AM, V2 (DON/Director of Nursing) said staff should perform hand hygiene before incontinence care, during incontinence care after cleaning the resident, and again after finishing incontinence care before going to the next resident's room. V2 said after cleaning the resident, the staff member's gloves would be dirty so they have to change them and perform hand hygiene. V2 said it is an infection control issue to go from a dirty area to a clean area with the same gloves on and the harm in this practice is contamination.</p> <p>R16's MDS (Minimum Data Set) dated 8/14/24 shows she is dependent on staff for personal hygiene and she is frequently incontinent of urine and always incontinent of stool. R16's Care Plan last revised on 9/22/22 shows she has an ADL (Activities of Daily Living) self-care performance deficit related to osteoarthritis and lymphedema. Interventions include that she is dependent assist x1 staff member for toilet hygiene</p> <p>The facility's policy titled, Resident Perineal Care last reviewed 6/24 states, Purpose: Protection of skin integrity, cleansing of perineum and prevention of infection and odor. Procedures: .6. Dry perineal and anal area. 7. Remove gloves, perform hand hygiene and apply new gloves. 8. Apply appropriate product: brief, pad, or other .</p>		

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<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>41384</p> <p>Based on interview and record review, the facility failed to offer COVID-19 vaccines to the facility's staff members and failed to provide education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine. This has the potential to affect all residents at the facility.</p> <p>Findings include:</p> <p>On 09/11/24 at 01:06 PM, V2 DON (Director of Nursing) said that he did not have any documentation to provide that the facility is offering the staff the COVID-19 vaccine or offering education about it. V2 said that the facility doesn't offer it anymore because it is too expensive.</p> <p>On 09/12/24 at 02:54 PM, V2 said that the facility has not offered any COVID-19 vaccine education to the staff in the last year.</p> <p>On 09/12/24 at 12:00 PM, V1 (Administrator) said that she has been at the facility since November 2023 and the facility has not offered COVID-19 vaccines to the staff or has had a COVID clinic since she has been here. V1 said that the facility should be offering the COVID-19 vaccine to staff.</p> <p>On 09/12/24 at 10:39 AM, V5 (Nurse) said that the facility has not offered the COVID-19 vaccine to him this year.</p> <p>On 09/12/24 at 10:41 AM, V6 (Housekeeping) said that the facility has not offered her the COVID-19 vaccine since 2020.</p> <p>On 09/12/24 at 10:57 AM, V4 (Wound Nurse) said that the facility has not offered her the COVID-19 vaccine.</p> <p>On 09/12/24 at 10:51 AM a sign on the wall in the entrance to the facility was observed, the sign showed, this establishment makes available opportunities for staff to be fully vaccinated against COVID-19. Please see your administrator for further information.</p> <p>The facility's COVID-19 Interim Measures policy (6/2/23) showed, for employees who have not received their COVID-19 vaccination but desire to receive one, the facility will discuss avenues for future vaccinations.</p> <p>At the time of this survey, the facility's CMS 671 form (Long-Term Care Facility Application for Medicare and Medicaid) showed a census of 46 residents.</p>		