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 _____	02/04/2013

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VILLAGE AT VICTORY LAKES, THE	1055 EAST GRAND AVENUE LINDENHURST, IL 60046

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F 441	Continued From page 38 include Hypertension, Cerebrovascular Accident with Right Hemiplegia and Type II Diabetes Mellitus Contact. R3 developed Urinary Tract Infection with ESBL (Extended Spectrum Beta Lactamase) of the urine. R3 was placed on contact isolation and treated with antibiotics. Repeat urine culture on 1/26/13 showed that R3 now has urine MRSA (Methicillin Resistant Staphylococcus Aureus. On 1/29/13 at 11:45 AM, Z1 (Nurse Practitioner) was observed donning a mask and gloves prior to entering R3's room. Z1 covered the end of her personal stethoscope with a glove and brought it in the room. Z1 did not wear an isolation gown. Z1 stated on 1/29/13 at 12:20 PM that she performed physical examination on R3 and used her stethoscope to auscultate the resident's chest area. Z1 said that she did not wear a gown because she did not touch any surface or object in the room. The undated facility policy based on CDC (Center for Disease Control and Prevention) guidelines titled, "Infection Control Practices," require, "III.B.1. Contact Precautions - Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain the pathogens."	F 441		
F9999	FINAL OBSERVATIONS Licensure Violations	F9999		

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F9999	Continued From page 39 300.610a) 300.1210b) 300.1220b)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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. Restorative measures shall include, at a minimum, the following procedures:	F9999		

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F9999	Continued From page 40 Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on observation, interview and record review, the facility failed to provide resident specific interventions, reevaluate the effectiveness of interventions and provide adequate supervision and assistance to prevent	F9999		

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F9999	Continued From page 41 reoccurring falls. This applies to 2 of 9 residents (R14 and R15) reviewed for falls in the sample of 18. This failure resulted in R14 sustaining a left hip fracture, after a fall on 10/17/12. Findings include: 1. R14 has multiple diagnoses which include Alzheimer's Disease and Dementia. On 1/30/13 at 1:30 PM, R14 was observed ambulating with assistance from the staff using a gait belt and a rolling walker. R14's annual MDS (Minimum Data Set) dated 7/24/12 was coded to reflect that the resident has orientation problem and required limited assistance x 1 person physical assist with transfers and ambulation. The same MDS indicated that R14 required extensive assistance x 1 person physical assist with toilet use (how resident uses the toilet room, transfer on/off toilet). R14's fall risk screening tools dated 4/6/12, 10/24/12 and 10/31/12 all indicated that the resident is high risk for fall. R14's electronic incident report dated 10/17/12 (4:40 PM) indicated that the resident fell in the bathroom, "Aid was by the door her back against the resident and trying to grab some gloves and when she turned the resident is calling and sitting	F9999		

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on the floor." The incident report also stated that R14 was trying to stand up, her pants were halfway through her knees. Upon assessment, R14 was complaining of left leg pain upon movement and left foot was noted to be externally rotated. MD called and ordered to send R14 to hospital ER for evaluation. 911 was called and transported resident to hospital ER for evaluation. The incident report indicated that R14 was admitted to the hospital with diagnosis of left hip fracture.

In an interview held on 1/31/13 at 1:47 PM, E3 (Certified Nursing Assistant, CNA) stated that on 10/17/12 before supper time, she took R14 to the toilet. Per E3 she left R14 on the toilet to get gloves. While she was outside the washroom door, she heard a "thump" and when she went back inside the washroom she saw R14 on the floor, with her (R14) pants and brief halfway down her legs. According to E3, she was not aware that R14 was assessed to be a high risk for fall. E3 stated that, if she was aware that R14 is a high risk for fall, "I would have hollered for another staff to bring in gloves, because I will not leave R14 alone in the washroom." Per E3, R14 is confused and prior to the resident's fall incident on 10/17/12, resident had a behavior of "just getting up/jumps up" without assistance and would fall. E3 stated that R14 had fallen before. E3 also added that at the time of the incident on 10/17/12, R14 did not have an alarm in place.

Review of R14's records reflected history of fall on 6/7/11 at 5:45 PM. The resident was found lying on the floor inside the bathroom. R14 complained of pain at the back of the head, left arm, knees and back. R14 was also noted with

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swelling and redness on the left arm and two pinpoint redness at the left side of the back of the head. Further review of R14's fall history reflected a fall on 7/13/11 at 10:35 PM. R14 got out of bed without assistance to go to the bathroom. While ambulating to the bathroom R14 began urinating and slipped on the floor, hitting her back and left side of the head on the dresser. R14 complained of back pain and was noted to have bruising on the back measuring 10 x 10 cm. R14 was noted with bump on the left side of the head.

R14 has history of falls with injury and was identified by the facility as high risk for fall. However, no fall care plan was in place during the fall incident of 10/17/12.

2) R15 is a 95 year old resident who was admitted to the facility on 6/11/2009 with diagnoses including anemia, dementia and osteoarthritis. Review of MDS (Minimum Data Set) dated 11/14/2012 and 12/26/2012 identified R15 requiring extensive assistance with 1 person physical assist for transfers and mobility. Review of the "Fall Risk Assessment" dated 8/8/2012 and 11/9/2012 showed that R15 is a high risk for fall.

R15 was observed on 1/28/13 at 11:45 A.M. and 1/29/2013 at 1:30 P.M. R15 was sitting in his wheelchair in the dining room. R15's upper body was leaning forward and had poor trunk control.

A review of the facility's incident reports showed that R15 sustained 9 fall incidents for a period of 7 months (6/2012 to 1/2013). The incident reports documented R15's fall episodes:
1) 6/24/2012 at 11:35 A.M. "found on the floor (R15's room) , sustained cut , frontal lobe

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F9999	Continued From page 44 measures 1 and 1/4 (centimeter) cm and 3 cm. bleeding noted." 2) 8/10/2012 at 4:45 A.M., "bed alarm going off, (R15) found on the floor (R15's room)" 3) 10/13/2012 at 7:15 P.M., "(R15) found on the floor (in his room)" 4) 11/26/2012 at 3 P.M."heard calling, (R15) found on the floor (in his room) " 5) 12/5/2012 at 9:55 P.M., "heard alarm, (R15) fell out of bed while trying to go bathroom" 6) 12/7/2012 at 3:20 A.M., "found sitting on the floor (in his room), unable to relate what happened" 7) 12/17/2012 at 2:25 A.M. "alarm going off, (R15) found kneeling on the floor" 8) 12/26/2012 at 4:30 P.M. "alarm going off, (R15) found on the floor (in his room) " 9) 1/19/2013 at 10:40 P.M., "heard bed alarm, (R15) found sitting on bedside floor mat " R15's current care plan did not include revised specific interventions after each fall. There were no adjustments in approaches or goals specific to R15's specific needs in order to prevent further fall. R15's incident report investigations showed that the falls were not analyzed to find the root cause in an attempt to prevent further falls. (B) 300.615 e) Determination of Need Screening and Request for Resident Criminal History Record Information	F9999		

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F9999	Continued From page 45 e). In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act). This requirement is not met as evidenced by: Based on interview and record review, the facility failed to request a Uniform Conviction Information Act, (UCIA) criminal history background check based on name, date of birth and other identifiers, within 24 hours of admission for 3 of 10, recently admitted residents reviewed, (R24,R25 and R26). Findings include Review of facility's printed recent admission record showed that R24,R25 and R26 were admitted to the facility on 1/18/2013. A further review of this admission record showed that it was on 1/20/2013 (2 days after admission) that the Criminal Background for R24, R25 and R26 were checked. On 1/30/2013 at around 2:00 P.M., E12 (Admission/ Discharge Coordinator) stated the criminal background check for R24, R25 and R26 were not check within 24 hours of their admission. E12 also added that E11 (Receptionist) was not able to check because of other duty task.	F9999		

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F9999	Continued From page 46 On 1/31/2013 at 11:30 A.M., E11 stated that " I was not able to check the background check timely because I was doing other task in regards to an ongoing flu outbreak at the facility." (AW)	F9999		