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 ______	06/24/2021

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VICTORIAN VILLAGE HLTH & WELL	12525 W RENAISSANCE CIRCLE HOMER GLEN, IL 60491

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.	F 578		6/26/21

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

Electronically Signed — 07/02/2021

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.

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F 578	Continued From page 1 (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the advance directive was correctly documented in case of emergency. This applies to 1 of 4 residents (R12) reviewed for Advance Directives in the sample of 12. The findings include: R12's face sheet showed that she was admitted to the facility on 05/5/21 with diagnosis including adult failure to thrive, encounter for attention to gastrostomy, enterocolitis due to clostridium difficile, unspecified protein calorie malnutrition, neoplasm related pain, encounter for antineoplastic chemotherapy and antineoplastic radiation therapy, anemia, hypertension, gastro-esophageal reflux disease without esophagitis. On 06/21/21 at 6:45 PM, R12's EMR (electronic medical records) showed that R12's face sheet and POS (Physician Order Sheet) included Full Code under Advance Directives. The same EMR showed a scanned copy of R12's form "Practitioner's Order for Life-Sustaining Treatment" (POLST) that was signed and dated by legal representative, witness and authorized practitioner on 5/11/21 with R12's choice for end-of-life care was "Do Not Attempt	F 578	F578 Advanced Directives Victorian Village Health & Wellness has established and maintains accurate Advanced Directives. Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: R12 is no longer a resident of this facility. Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The Measures the facility will take to ensure the problem will be corrected and will not reoccur: Medical records of current residents have been audited to ensure a physician order is in place for correct Advance Directive. Nurses have been in-serviced on correct procedure for documentation of Advance Directives. See attachment (A) Quality Assurance plans to monitor facility performance to make sure corrections are	

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F 578	Continued From page 2 Resuscitation" (DNR). On 06/22/21 at 09:34 AM, V2 (Director of Nursing) stated that R12 may have changed her status from full code on admission to DNR on 5/11/21 and the facility should have updated the face sheet and POS to reflect the same. On 6/23/21 at 1:45 PM, V13 (Director of Admissions and Social Service), stated that on admission, if the hospital does not present DNR , the resident is automatically a full code. V13 stated that she confirms the advance directive status and Power of Attorney a day after admission. V2 stated that R12's medical records should have been updated to reflect R12's choice for DNR status. Facility policy and procedure titled "Advance Directives" (effective 10/95) included the following: 1. During admission process, [facility] will provide each client with a [facility]statement of advance directives reviewing how the individual's rights to make health care decisions and to formulate an advance directive are implemented. 3. Advance directives should be clearly stated in writing. Specific forms such as DNR, Durable Power of Attorney (Healthcare & Finance), POLST or Living Will are acceptable but not necessarily required. 5. The decision to execute an Advanced Directive shall be documented in the medical record.	F 578	achieved: The Director of Nursing/designee shall audit 4 charts/week for 8 weeks to ensure a physician order is in place for correct Advance Directive and is reflected in the EMR. See attachment (B) These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. The Director of Nursing and/or designee shall assure the completion of this process.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		6/26/21

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F 677	Continued From page 3 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide grooming for residents that required extensive assistance for the same. This applies to 3 of 6 residents (R23, R94, R196) reviewed for ADL (activities of daily living) in the sample of 12. The findings include: 1. R196's face sheet included diagnosis of unspecified Dementia with behavioral disturbances, altered mental status, dysphagia, nutritional deficiency, pain unspecified, abnormal findings in blood chemistry, constipation. R196's 5 day MDS (minimum data set) dated 6/11/21 showed that R196's required extensive assistance of 1 person physical assist for personal hygiene. R196's active/current ADL care plan included the following: Problem-Functional ADL deficit due to deconditioning, cog [cognitive] loss. Goal-[R196] will be assisted as needed to allow for maximum functional independence to stay clean, dry and well groomed. (goal date 9/10/21). On 06/21/21 at 11:37 AM, R196 was seen seated in wheel chair in her room and noted to have multiple long chin hairs. R196 stated that her vision is "not too good" and that she requires assistance. On 06/22/21 at 11:40 AM, 2:06 PM, R196 was in	F 677	F677 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS Victorian Village Health & Wellness does assure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: R196 had long chin hairs removed from chin. R23 was shaved and fingernails trimmed and cleaned R94 had fingernails trimmed and cleaned Actions taken to identify other residents that have the potential to be affected by the deficient practice: All dependent residents who require ADL care have the potential to be affected by the deficient practice. The Measures the facility will take to ensure the problem will be corrected and will not reoccur: The facility has in-serviced all nursing staff on providing proper grooming to residents as needed including general grooming, facial hair, and fingernails. See	

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F 677 Continued From page 4

her room and still had the facial hair that was observed the day before and this was relayed to V7 (Registered Nurse).

On 06/23/21 at 12:03 PM, V2 (Director of Nursing) stated that the care partners are responsible to take care of hygiene and grooming on shower and bed bath days. V2 stated that personal hygiene care should include fingernails and toe nails to be clipped and/or cleaned and facial hairs removed.

Facility policy and procedure titled "A.M Care (Early Morning)" included the following:
Policy: A.M Care provided to prepare the client for daily activities, promote good health, hygiene and well being.

2. From 6/21/21 through 6/23/21, R23 was observed with unkept overgrown facial hair and slightly long dirty fingernails (with black/brown substance underneath nails). On 6/21/21 at 2:02 PM, V6 (Certified Nursing Assistant/CNA) rendered incontinence care to R23. After completing the care, V6 left the room without offering to provide shaving and nail care.

On 6/23/21 at 12:10 PM, R23 was resting in bed still displaying unkept overgrown facial hair and slightly long dirty fingernails. When asked if he wants to be shaven and his nails to be clipped, R23 touched his face and looked at his fingernails and responded by saying "Sure why not, that would be nice."

MDS (Minimum Data Set) dated 5/27/21 showed that R23 requires extensive assistance for grooming/hygiene.

F 677

attachment (C)

Quality Assurance plans to monitor facility performance to make sure corrections are achieved:

The DON and/or designee will observe 5 residents/week for 8 weeks to ensure ADL needs are being met. See attachment (D)

These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring.

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F 677	Continued From page 5 Active care plan showed that R23 has functional activities of daily living (ADL) care deficit due to deconditioning. R94 will be assisted as needed to allow for maximum potential independence to stay clean, dry, and well groomed. 3. From 6/21/21 through 6/22/21, R94 was observed in his room displaying long dirty fingernails with black/brown substance underneath nails. On 6/22/21 at 1:26 PM, V12 (CNA) provided incontinence care to R94. After completing the care, V12 left the room without offering nail care to R94. MDS dated 6/16/21 showed R94 requires extensive assistance for hygiene/grooming On 6/23/21 at 12:47 PM, R96 was stated that the staff clipped his nail this morning. MDS 6/16/21 showed that R94 requires extensive assistance for hygiene. Active care plan showed that R94 requires extensive assistance for personal hygiene. R23 will have oral hygiene, hair combed, and other personal hygiene needs to be met daily.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		6/26/21

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F 684	Continued From page 6 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow standard infection control practices related to changing of gloves and hand hygiene during provisions of care and failed to ensure that staff avoids cross contamination between clean and soiled objects during incontinence and wound care. This applies to 3 of 5 residents (R23, R32, R96) observed for incontinence care and wound care in the sample of 12. The findings include: 1. On 6/21/21 at 1:45 PM, V6 (Certified Nursing Assistant/CNA) assisted R96 to the toilet. V6 pulled R96's pants down and removed his soiled incontinence brief. V6 went back to R96's bedroom and while wearing same soiled gloves she (V6) opened the closet door to get a new incontinence brief, she also touched the bed's control to adjust its height and cleaned the overbed rolling table. At 1:53 PM, V6 returned to assist R96 from the toilet. V6 wiped R96's back and frontal peri-area, put a clean incontinence brief, pulled pants back up, assisted R96 back into the wheelchair and propelled him back to the bedroom while wearing same soiled gloves. V6 went out of the bedroom, carried soiled towels and garbage still wearing same soiled gloves. 2. On 6/21/21 at 2:02 PM, V6 (CNA) rendered peri-care/incontinence care R23 who had a bowel movement. V6 cleaned, R23's frontal perineum and catheter tube, then V6 placed the soiled wipes in the overbed rolling table beside the	F 684	F684 Quality of Care Victorian Village Health & Wellness has established and maintains standard infection control practices. Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: R23, R32, and R96 were immediately assessed with no adverse effects as a result of the deficient practice. Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The Measures the facility will take to ensure the problem will be corrected and will not reoccur: Facility staff has been in-serviced on proper hand hygiene procedures and infection control practices. See attachment (E) Quality Assurance plans to monitor facility performance to make sure corrections are achieved: The DON and/or designee shall observe 5 residents/week for 8 weeks to ensure	

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F 684

Continued From page 7

drinking pitcher. While wearing same gloves, V6 went to R23's closet to get a new incontinence brief. V6 removed her soiled gloves and placed it directly beside and in contact with R23's clean water pitcher along with the soiled wipes. V6 donned another set of gloves without hand hygiene and proceeded to clean R23's buttocks. She went to other side of R23 to continue to wipe R23's buttocks. She removed her gloves and placed it in the overbed table. V6 left the room with no hand hygiene, she returned and continued to assist R23 with positioning and straining his clothes and bed linen. Afterwards, V6 gathered the garbage, she opened the door with gloved hand and carried the garbage to the soiled utility room. V6 removed her soiled gloves, with no hand hygiene, she donned another set of gloves went back R23's room to get the soiled linen and placed it in the linen bag then she went to soiled linen room while wearing soiled gloves. V6 did not sanitize the areas/surfaces and objects she touched while wearing her soiled gloves.

3. On 6/22/21 at 2:17 PM, V9 (Nurse) provided wound care to R32 who has a pressure ulcer in the left heel. V9 cleaned the wound with a gauze with normal saline solution. Then V9 placed the used gauze on the overbed rolling table along with clean dressing and treatment materials. The soiled gauze was also directly touching R32's clean drinking water pitcher. V9 removed her soiled gloves and sanitized hands in between tasks, however, V9 placed the soiled gloves along with the used gauze, clean dressing/treatment materials and water pitcher.

On 6/22/21 at 3:13 PM, V2 (Director of Nursing/DON) stated that the staff must sanitize hands before entering and leaving a resident's

F 684

proper Infection Control practices are exhibited by staff, along with proper hand hygiene during care of resident. See attachment (F)

These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring.

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F 684	Continued From page 8 room. The staff should also sanitize hands and change gloves when they are switching from clean to dirty task during provisions of care, this is to prevent cross contamination and potential infection. Dirty or used wipes, gloves and gauze should be disposed of right away in a garbage bin so it doesn't touch or contaminate anything else. Facility's Policy and Procedure for Infection Control for All Nursing Procedures showed: Types of Precautions: 1. Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, specific body fluids, secretions, excretions regardless of whether they contain visible blood, non-intact skin, and or mucous membranes. 4. In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: f. Before moving from a contaminated body site to a clean body site. g. After contact with a resident's skin. h. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident. i. After removing gloves.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/26/21

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F 686	Continued From page 9 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess for pressure relief a resident who was wearing a foot enclosed in an orthotic boot. This failure resulted to the resident sustaining unstageable pressure ulcer in the left heel. This applies to 1 of 3 residents (R42) reviewed for pressure ulcer in the sample of 12. The findings include: Face sheet indicate that R42 is 72 years-old, she has multiple medical diagnoses which include fracture of unspecified part of neck of the left femur, dislocation of internal left hip prosthesis, foot drop (left foot). Admission note showed that R42 was admitted to the facility on 6/5/21 wearing an orthotic boot on the left foot. MDS (minimum data set) dated 6/12/21 indicated that R42 is alert and oriented and requires extensive assistance for bed mobility, locomotion, dressing toileting and personal hygiene.	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer Victorian Village Health & Wellness does assure that all residents receive care consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual s clinical condition demonstrates that they were unavoidable Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: R42 is seen regularly by our Wound Care Physician. Treatment for heel had been given and is done as ordered. Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice.	

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F 686	Continued From page 10 R42's Braden Scale Risk Assessment (Skin Assessment) dated 6/5/21 showed that R42 is very high risk for skin breakdown. On 6/21/21 at 3:00 PM, R42 was resting in bed, she was awake, alert, and oriented. R42 has a wound dressing to her left foot. R42 stated, she had multiple surgeries in her left lower extremities in the past month related to a fall incident at home resulting into a fracture. She was admitted to the facility a few weeks ago (6/5/21), with an orthotic boot on her left foot. R42 said that the boot was placed on her from the hospital. Since then, the boot has been on her, without anyone visually assessing her left foot that was enclosed in the orthotic device. R42 has been complaining on and off pain/burning sensation to her left foot. The pain was more intense at nighttime. R42 would tell staff about the pain and they would loosen up the boot which gave her a feeling of relief. However, no one had ever removed the boot to assess her foot. One day (6/16/21), one of the staffs was assisting her for hygiene care (R42 was unable to re-call who it was) suggested to clean her feet. The staff removed her boot and found the pressure ulcer. On 6/22/21 at 8:52 AM, V3 (Wound Care Nurse) stated that R42 had a surgery on her left hip, she was wearing a PRAFO (Pressure Relief Ankle Foot Orthosis) boot on her left foot upon admission to the facility. It was reported that R42 was complaining of pain on her left foot, and upon assessment (on 6/16/21) she had an open skin in the left heel which was unstageable due to slough formation in the wound bed. V3 also stated that she was not sure if the staff who admitted R42 did a full body assessment. However, the facility's	F 686	The Measures the facility will take to ensure the problem will be corrected and will not reoccur: Nursing staff has been in-serviced on proper body/skin assessment on admission. Also instructed to remove any appliance/device (if not contraindicated) daily to do skin inspections. See attachment (G) Quality Assurance plans to monitor facility performance to make sure corrections are achieved: The Director of Nursing/Designee will audit 5 residents with appliances/devices for 12 weeks to ensure it was removed and skin assessed as ordered. Also, to ensure that if any skin issues were identified as a result of the appliance/device, that the MD/NP was notified. See attachment (H) These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring.	

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VICTORIAN VILLAGE HLTH & WELL	**12525 W RENAISSANCE CIRCLE HOMER GLEN, IL 60491**

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F 686	Continued From page 11	F 686		

policy requires staff to do a full body assessment which include a head to toe skin assessment upon admission. The PRAFO boot was placed on R42 for her foot drop and not for offloading. This device was lined with sheep skin (fur) for comfort, but with R42's boot, the lining in the heel area had worn off and her left heel was resting directly on the frame of the boot which put pressure on it.

On 6/22/21 at 11:39 AM, V3 rendered wound care to R42's unstageable pressure ulcer in the left heel. R42 repeated what she said from the day before that no one had assessed or seen her left foot until 6/16/21. R42's orthotic boot was shown to surveyor. The boot had a soft inner lining, however, the lining of the heel area had flattened and hardened from the secretions of her wound.

On 6/22/21 at 10:15 AM, V7 (Nurse), stated that on 6/16/21 V10 (Occupational Therapist/OT) notified V7 about R42's wound. V10 was assisting R42 and took off the boot. V10 found the wound and immediately notified V7. V7 stated "R42 told me that she has been complaining of pain to the nurse. Everyday each shift has a group of residents who are responsible for a full body assessment of each residents for Medicare charting. R42 is assigned to night shift staff and I believed that the orthotic boot order indicates to keep it on while in bed. I should have also check but I didn't. She is high risk for pressure ulcer and has history of pressure sore in the left and right buttocks and upper posterior left thigh. Had she (R42) said anything to me I could have assess it right away and take care of the problem."

On 6/22/21 at 12:18 PM, V8 (Wound Care Physician) gave the following statement: If a resident has some sort of removable device and

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F 686	Continued From page 12	F 686		

the resident started to complain of pain related to it, the staff must remove the device and do an assessment. If the staff is not sure whether to remove the device, they should call the physician. If V8 was notified about this type of concern, V8 would have instructed the staff to remove the boot and do a skin assessment. This situation could have been prevented. If the staff had done it right away, it could have been caught as stage 1 or DTI. Loosening the boot does not relieve the pressure from the foot.

On 6/22/21 at 3:35 PM, V11 (Nurse), stated that when R42 first came in, they (staff) did a full body assessment. V11 took R42's boot off when she complained of burning sensation to her foot. When V11 assessed R42's heel, she (V11) noted that it was a little boggy (extra soft which was unusual). V11 put barrier cream to the left heel for comfort and removed the boot temporarily and placed R42's foot on top of a pillow to relieve the foot. V11 also said she could not recall calling the doctor about it.

On 6/23/21 at 12:12 PM, V2 (Director of Nursing/DON) stated that when a resident is admitted with splints or supporting device the staff must take off the device and completely assess what is underneath. The staff should also remove the device during shower days to assess the skin, and if the staff is not familiar with the resident, they should remove device and assess the skin.

R42's progress notes was reviewed, and it showed documentation from 6/5/21 through 6/15/21 of R42's left boot in place due to foot drop, able to wiggle toes and was noted to have edema to both lower extremities. A physician note

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dated 6/9/21 showed that R42 has high risk for developing contractures, pressure ulcers, poor healing or fall if not receiving adequate therapy and pain control. The 6/16/21 progress note showed that a wound was found on the left heel which extended up to the Achilles tendon with the circular portion measuring Length (L) 5.0 centimeter (cm) x Width (W) 5.0 cm x Depth (D) 0.2 cm. The wound bed was covered 40% with slough and partial scabbing in the remaining 60%. The wound appears to be pressure related.

There was no evidence of documentation that R42's left foot was fully assessed, and the boot was ever removed for foot relief prior to the discovery of her pressure ulcer. Facility was unable to present documentation actual skin assessment done during shower or bathing time.

Facility's Pressure Injury Reduction Policy and Procedure showed:

Policy: Skin assessments and risk assessments for pressure injury are performed, individualized care plans are formulated to address identified needs, and interventions are implemented, monitored, as needed to reduce the incidence of pressure injuries, and promote healing of existing injuries.

Procedures:
1. All clients receive a skin assessment to identify the status of the skin and note areas of skin compromise such as pressure injury, wound bruise, skin tear, surgical site, other. The skin assessment is performed beginning on admission/re-admission. Skin integrity is monitored routinely in the course of care, and skin compromises that may be noted are reported

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F 686	Continued From page 14 to the nurse.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		6/26/21

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F 690	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide peri-care/incontinence care in a manner that would prevent urinary tract infection (UTI). This applies to 2 of the 5 residents (R23 and R96) observed for bowel, bladder, and urinary catheter care in the sample of 12. The findings include: 1. R23's care plan showed that R23 has an indwelling urinary catheter due to urinary retention. On 6/21/21 at 2:02 PM, V6 (CNA) rendered peri-care/incontinence care R23 who had a bowel movement. R23's catheter tube was not anchored/secured, and it was pulling/tagging during peri-care and repositioning. V6 cleaned, R23's frontal perineum and catheter tube. After changing gloves, she proceeded to clean the buttocks. V6 used wet wipes to clean R23, there were still fecal matter observed in R23's skin (in between inner buttocks) when V6 applied the clean incontinence brief. V6 was prompted to redo it again and the wet wipes was stained with fecal matter after she wiped R23 again. 2. R96's face sheet showed that he (R96) is 95 years old with multiple medical diagnoses to include, BPH (Benign Prostatic Hyperplasia) without lower urinary tract symptom. On 6/21/21 at 1:53 PM, R9 used the toilet to void. Then V6 assisted R96 to stand up and she used the same wet wipes to clean him from buttocks to	F 690	F690 Bowel/Bladder Incontinence, Catheter Victorian Village Health & Wellness does assure residents who are incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Corrective Actions taken for those residents alleged to have been affected by the alleged deficient practice are: R23 and R96 were immediately assessed with no adverse effects noted as a result of the deficient practice. Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The Measures the facility will take to ensure the problem will be corrected and will not reoccur: Nursing staff have been in-serviced on proper hand hygiene and infection control practices to adhere to while providing incontinent care to residents. See attachment (I) Quality Assurance plans to monitor facility performance to make sure corrections are achieved: The Director of Nursing/Designee will monitor 5 residents/week receiving	

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F 690	Continued From page 16 the front penile in haphazard way. V6 hurriedly applied the clean incontinence brief without thoroughly cleaning the peri-area (the groins and scrotal area were not cleaned). On 6/22/21 at 3:10 PM, V2 (Director of Nursing/DON) stated that incontinence care should be done from front to back with different wipes. The must clean the peri-area thoroughly. Staff must ensure that they dry the skin properly and ensure fecal matter is totally wiped off. To promote comfort, prevent skin breakdown, prevent infection. V2 also stated that she is not sure regarding the facility's policy regarding securing urinary catheter tube on the resident. Facility's Policy and Procedure for Incontinence Care showed: Policy: Incontinence care is provided to keep the skin clean and dry, promote comfort, and maintain skin integrity. Procedures: 2. Wash all soiled skin areas and dry very well, especially between skin folds. Facility's Catheter Care Policy and Procedure showed: Policy: Foley catheter care is provided to prevent infection and irritation. Procedure: 3. If client is incontinent of stool, clean anal area first. Be careful not to contaminate catheter insertion site.	F 690	incontinent care for 8 weeks to ensure proper Infection Control practices and good hand hygiene are being exhibited by staff. See attachment (J) These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring.	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		6/26/21

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F 803	Continued From page 17 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow menu diet spread sheets for the lunch meal. This applies to 5 of 5 residents (R25, R42, R196, R199, R200 reviewed for dining in the sample of 12. The findings include:	F 803	F803 Menus meet Res Needs/ Prep in Advance/ Followed Victorian Village Health & Wellness has established and uses appropriate scoop sizes for meal preparation and service. Corrective Actions taken for those residents alleged to have been affected by	

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F 803	Continued From page 18 On 06/21/21 at 12:05 PM, V5(cook) was observed plating food for the lunch meal for the 2nd floor residents in the facility kitchen. V5 used a blue colored scoop (#16) to plate pureed cabbage and pureed potatoes respectively to R196 and and R199. V5 also used a green colored scoop (#12) to plate pureed pork tenderloin to R196. V5 used a green colored scoop (#12) to serve ground pork tenderloin to R25 and R200. R25 also received potatoes with skin. V4 also used a green colored scoop (#12) to serve (regular) rice to R42 and R200. Facility diet extension sheets for Monday 6/21/21 cycle 9 showed to use #12 scoop for pureed cooked cabbage and # 8 scoop for pureed potato, #8 scoop for (regular) rice The same extensions showed that mechanical soft diets should receive roasted potato medley with no skin. The same extension sheet did not indicate a scoop size for pureed pork tenderloin. On 06/21/21 at 12:15 PM, V4 (Dietary Manager) stated that the scoop sizes and consistencies as indicated on the menu spreadsheets should have been followed. V4 stated that she had instructed V4 to use a #8 scoop size to serve pureed pork tenderloin as it was not reflected on the menu. Facility scoop equivalents sheet showed that #16 blue scoop =2.07 oz/ounce, #12 green scoop =2.78 oz, #8 gray scoop=3.64 oz Facility diet order included R25 and R200 on mechanical soft diets, and R196 and R199 on pureed diets and R42 on regular diet.	F 803	the alleged deficient practice are: R200 is no longer in the facility. R25, R196, R199, R42 were immediately assessed with no adverse effects noted as a result of the deficient practice. Actions taken to identify other residents that have the potential to be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. The Measures the facility will take to ensure the problem will be corrected and will not reoccur: Facility staff has been in-serviced on proper scoop sizes and consistencies. See attachment (K) Quality Assurance plans to monitor facility performance to make sure corrections are achieved: Quality assurance tools have been developed and implemented to randomly observe food prep to ensure staff are using proper size scoops and assure compliance with recipes. The Director of Dining and/or designee shall audit facility staff to assure compliance 3x/week for 8 weeks. See attachment (L) These results will be reviewed and discussed by the Interdisciplinary Team through the Quality Assurance process	

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F 803	Continued From page 19	F 803	and corrective action plans put into place as indicated based on review, along with determinations related to ongoing monitoring. The Director of Dining and/or designee shall assure the completion of this process.	