STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ASL510377	A. BUILDING: _____ B. WING _____	07/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORIAN INN	12600 RENAISSANCE CIRCLE HOMER GLEN, IL 60491

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A 000	Initial Comment Annual Licensure Survey The following were cited: 295.3000 a) h)1)2)3)7) 295.4000 a)b)c)g) 295.4010 a)d)e)g)A)C)2)3) - REPEAT VIOLATION	A 000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: General Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient personnel to provide the following for its current resident population: 1) All mandatory services; 2) Services established in each resident's service plan; 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; 7) Any optional services to be provided by the establishment as stated in the service plan. These requirements were not met as evidence	A3000		

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A3000	Continued From page 1 by: Based on interview and record review, the facility failed to: 1. Provide supervision to residents identified as at "risk" for fall. 2. Obtain R2's baseline- range of motion assessment and to provide monitoring for possible complications. 3. Develop and implement an individualized plan of care to address the identified needs of the residents. These failures resulted in the following: 1. On April 26, 2025, R2 sustained left hip fracture with surgical intervention. 2. R5's multiple major injuries: (a) Multiple fracture on the left ribs on March 9, 2024. (b) Laceration to the back of the head- skin glued together on April 20, 2025, (c) Displaced fracture of the proximal humerus.May 15, 2025, This for two of two residents (R2 and R5) resident selected with fall incidents. Findings include: 1. R2 move in the establishment on October 30, 2024, with diagnoses to include dementia with behavioral disturbances, Parkinson, anxiety disorder, tremors, and glaucoma. The Nurse Practitioner assessment, dated April 16, 2025, identify R2 with unsteady gait, with lower extremity weakness and mild tremors. On July 10, 2025, at 3:44 PM, E2 (Director of Nursing/RN) and E7 (LPN) described R2 as confuse and disoriented, requires one physical	A3000		

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A3000	Continued From page 2	A3000		

assistance from the staff with all of activities of daily living; utilizes wheelchair- propel by the staff. E2 identified R2 as at risk for fall.

On April 26, 2025, at 22:28, the R2's nurses notes show an unwitnessed incident; R2 was found in the bathroom floor and documented: "slide out of bed", transfer self into wheelchair then scooted to the bathroom to pull the alert cord to notify staff. Denies hitting head, no injuries, or any discomfort. Assisted back-to-back the bed. Neuro checks initiated.

There was no base line range of motion obtained and documented.

On April 29th, 2025, at 10:34 AM, the Physical Therapist stated that R2 would not bear weight on the left leg and could not complete the session. R1 complaint of left hip pain. X-ray show a left hip fracture. R1 was sent and admitted to the hospital.

R2 was readmitted to the establishment on June 4, 2025, on July 1, 2025, at 4:53 AM, R2 sustained another unwitnessed incident. R2 was found on the floor, "slipped from the bed to the floor..." There was no comprehensive assessment documented.

2. R5 originally moved in the establishment on November 15, 2023, with diagnoses to include anemia, hypothyroid and history of falling.

On July 10, 2025, at 4:47 PM, E7 described R5 with cognitive impairment, requires one physical assistance from the staff with all of activities of daily living; a wheelchair bound- propel by staff

The following are the recorded incidents with

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A3000	Continued From page 3 injuries: - On March 9, 2024, unwitnessed fall. R5 was sent and admitted with diagnosis of multiple fractured left side of the ribs. - April 20, 2025, R5 sustained a laceration to the back of head; R5 skin was glued together. - On May 15, 2025, R5 sustained fracture humerus due to an unwitnessed incident. There were no investigations conducted to analyze R5's incidents that resulted to these major injuries. R5's Service plan failed to include interventions to minimize R5's risk for fall.	A3000		
A4000	Section 295.4000 Physician/s Assessment This Regulation is not met as evidenced by: General Violation Section 295.4000 Physician's Assessment a) No more than 120 days prior to admission of a resident to any establishment, a comprehensive assessment that includes an evaluation of the prospective resident's physical, cognitive, and psychosocial condition shall be completed by a physician. The physician's assessment shall include documentation of the presence or the absence of tuberculosis infection in accordance with the Control of Tuberculosis Code. At the time of admission, the physician's assessment must reflect the resident's current condition. b) At least annually, once a resident has moved into the establishment, a comprehensive assessment shall be completed by a physician. c) A physician's assessment shall be completed by a physician upon identification of a significant	A4000		

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A4000	Continued From page 4	A4000		

change in the resident's condition.

These requirements were not me as evidence by:

Based on interview and record review, the facility failed to:
1. Have a physician to conduct and complete the physician certification prior to or upon admission and/or annually.
2. Complete a thorough assessment and to include the certified assessments as conducted.

These are for five of five (R2, R1, R3, R4 and R5) residents in the sample.

Findings include:

1. R2 moved in the establishment on October 30, 2024, with diagnoses to include dementia, anxiety disorder, Parkinson's and tremors.

R2's physician assessment dated August 23, 2024, was signed by nurse practitioner. When the establishment was asked for the annual certification, a blank physician assessment with a doctor's signature was presented. The date and the resident's name were type written; the rest of the form was blank.

2. R1 moved in the establishment on April 11, 2025, with diagnoses to include hyperlipidemia, hypertension, chronic kidney disease, chronic back pain.
On April 9, 2025, R1's certification conducted by an APN (Advanced Practice Nurse).

3. R3 moved in the community on June 5, 2023, with diagnoses including Alzheimer's disease, hypertension, anemia, spasmodic torticollis. R3 annual physician certification dated June 17,

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A4000	Continued From page 5 2025, includes R3's name and the signature of the nurse practitioner, the rest of the form was blank. 4. R4's physician certification dated April 17,2025, was signed by a Nurse Practitioner. 5. R5 moved in the establishment on November 15, 2023, with diagnosis of anemia, multiple fracture of the ribs and with history of falling. R5's initial physician certification shows a Nurse Practitioner signature; there was no certified assessment check as conducted.	A4000		
A4010	Section 295.4010 Service Plan This Regulation is not met as evidenced by: General Violation - REPEAT VIOLATION Section 295.4010 Service Plan a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan. d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act). e) The service plan shall be reviewed and	A4010		

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A4010	Continued From page 6 revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000). g) Service plans shall address: 1) The level of service the resident is receiving, including: A) assistance with activities of daily living. C) special accommodations for the resident. 2) The amount, type, and frequency of health-related services needed by the resident. 3) Staff responsible for the provisions of the service plan. These requirements were not met as evidence by: Based on observation, interview and record review, the facility failed to: 1. Conduct a revision and significant change of status based on the current assessments and as new risk factors identified in order to assist staff in providing the appropriate care and maintaining safety to the residents. These failures resulted in the following: 1. R2 sustained a left hip fracture on April 26, 2025. 4. R5 sustained the following injuries: A. April 20, 2025, a laceration to the right side on the back of the head, R5 was found on the floor bleeding from the back right side of the head. I was sent to the hospital, skin of the back of the head- glued together. B. March 25, 2025- with multiple left side fracture of the ribs. C. On May 15, 2025, R5 sustained displaced fracture of the proximal humerus. These are for 5 of 5 (R1 through R5) residents	A4010		

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A4010	Continued From page 7	A4010		

selected in the sample.

The findings include:

1. On July 10, 2025, at 3:44 PM, E2 (Director of Nursing/RN) and E7 (LPN) described R2 as confuse and disoriented, requires one physical assistance from the staff with all of activities of daily living; utilizes wheelchair for ambulation. E2 also identified R2 as at risk for fall.
R2 move in the establishment on October 30, 2024, with diagnoses to include dementia with behavioral disturbances, Parkinson, anxiety disorder, tremors, and glaucoma.
- The Nurse Practitioner assessment, dated April 16, 2025, identify R2 with unsteady gait, with lower extremity weakness and mild tremors.
- On April 26, 2025, R2 sustained left hip fracture with surgical procedure done (unidentified)
- On June 17, 2025, the Nurse Practitioner documented "with worsening behavioral symptoms " (no specific behavior was identified).
On July 10, 2025, at 4:47 PM, E7 explained, " R5 thinks, she's still independent, that's why she's been falling!"

These concerns were not address in R2's undated service plan. The fall interventions include:
- Is at risk for falls due to mobility decline.
- requires reminder to call for assistance and use a mobility device ... (R5 with diagnosis of Dementia).
- Reeducate on the importance of transferring with assistance.

2. R5 move in the establishment on November 15, 2023, with diagnosis of anemia and history of falling. Nurse Practitioner assessment show R5

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A4010	Continued From page 8	A4010		

as alert x 2, forgetful and with unsteady gait;
On July 10, 2025, at 4:47 PM, E7 (LPN), identified R5 with cognitive deficit, uses wheelchair, need one-person physical assistance with all of activities of daily living. E2 and E7 said, R5 is at risk for fall and sustained fall before with injuries.
E7 stated, "R5 takes herself to the bathroom, thinking she's still independent!"
This assessment was not identified in R5's fall Service plan - initiated November 16, 2023. R5's interventions include:
- Call for assistance when transferring to the bathroom. utilize assistive device.
- Continue to educate on benefits of utilizing call button.
- Risk for fall due to frequent falls.
- Remind to call for assistance.

R5 sustained the following injuries:

A. On April 20, 2025, R5 was found on the floor bleeding from the back right side of the head, was sent to the hospital, skin of the back of the head- glued together.

B. March 25, 2025- with multiple left side fracture of the ribs. There were no revision or significant changes done in R5's Service plan.

C. On May 15, 2025 R 5 sustained displaced fracture of the proximal humerus related to another witness incident of fall.

These findings were all discussed and confirmed by E1 (Executive Director), E2 (Director of Nursing) and E7 (LPN) on July 10, 2025.