

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0048256		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER VILLAGE AT VICTORY LAKES, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 1055 EAST GRAND AVENUE , LINDENHURST, Illinois, 60046			
(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
S0000	Initial Comments			S0000			
	Annual Licensure Survey						
S9999	Final Observations			S9999			
	Statement of Licensure Violations:						
	300.610a)						
	300.1210a)						
	300.1210b)						
	300.1210c)						
	Section 300.610 Resident Care Policies						
	a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	Section 300.1210 General Requirements for Nursing and Personal Care						
	a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. These requirements were not met as evidenced by: Based on interview and record review the facility failed to immediately identify the code status and initiate Cardiopulmonary Resuscitation (CPR) to a resident (R96) who had elected to be a full code. This failure resulted in an approximate 2–4-minute delay in initiating CPR to R96 who was pronounced deceased on 2/14/26 at the facility. This applies to 1 of 3 residents (R96) reviewed for resident death in the sample of 18. The findings include: R96's face sheet shows he was admitted to the facility on 1/27/26 with diagnoses including left below the knee amputee, pneumonia, and malignant neoplasm of the bladder and prostate. R96's Physician Order Summary initiated on 1/27/26 shows that R96 had elected to be a Full Code. R96's Care Plan dated 1/29/26 also shows R96 has elected to be a Full Code and facility staff should adhere to his desired code status. R96's nursing progress notes show R96 was started on an antibiotic for pneumonia on 2/13/26. R96's nursing progress notes then show on 2/14/26 at 6:00 AM, an entry completed by V6 (RN) shows V6 had been alerted by another nurse and CNA at approximately 5:26 AM, that R96 did not have any respirations or pulse and herself and another nurse then initiated CPR. Emergency Medical Services were contacted and arrived at the facility at 5:35 AM and took over CPR. R96 was pronounced deceased at 5:57 AM. On 3/10/26 at 2:20 PM, V6 said on 2/14/26 she was notified by both V3 (RN) and V5 (CNA) and in her opinion, without a sense of urgency that there was an issue with R96 and that "your patient is dead." V6 said she went to assess R96 and found him	S9999					

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S9999	Continued from page 2 without a pulse or respirations and she could not immediately remember if he was a full code or not. V6 said she went to check his code status and to grab her phone to call 911 and told V3 to begin CPR. V6 said she would guess from the time she was notified to CPR being initiated was less than 2 minutes, however she could not say how long had gone by since V5 first found R96 without a pulse. V6 said she had some concerns with how this code was handled and the fact that neither V3 nor V5 immediately implemented CPR to R96. V6 said when a resident is a full code and found without a pulse or breathing a code should be called and CPR should be initiated immediately without a delay. V6 said she could not speak for anyone else as to why they did not start CPR but she believes they were not aware of the residents code status. V6 said a residents code status is on a report sheet the nurses have as well as in the residents electronic medical record (EMR). On 3/11/26 at 10:05 AM, V3 (RN) said she was notified by a CNA (V5) sometime around 5:25 AM, on 2/14/26 that R96 "needed to be checked" V3 said she went to assess R96 and found him without a pulse and without any respirations. V3 said she could not recall her and V5 then leaving the room to go get R96's primary nurse V6, but she remembers she did CPR with V6. V3 said the report sheet is easily accessible to the nurses but she does not know for sure how a CNA knows a residents code status. On 3/11/26 at 10:25 AM, V2 (Director of Nursing) said if a resident is a full code CPR should be initiated immediately. V2 said she does not know why V5 did not call a code and initiate CPR maybe she panicked, and V3 also should have immediately started CPR instead of going to find V6, but maybe she did not know R96's code status. V2 verified that V3, V5 and V6 are all CPR certified. V2 verified that nurses have the residents code status on report sheets and that they are also in a residents electronic medical record. V2 said a CNA would have to ask a nurse for a residents code status or check the EMR if a resident is found down. On 3/11/26 at 12:55 PM, V5 said sometime around 5:30 AM, she went into R96's room and he did not wake up, which was not normal for him. V5 said she felt for a pulse and checked for respirations and R96 did not have either and she was not sure of his code status so she went and got V3 to verify that R96 wasn't breathing. V5 said V3 came to the room and verified that R96 was pulseless and they both left the room to go find V6 and confirm R96's code			S9999			

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S9999	Continued from page 3 status. V5 said this was the first time she had found a resident in need of CPR and looking back she should have called for help and immediately started CPR. V5 said she can only guess that it was less than 5 minutes from when she found R96 down to when CPR was finally initiated. On 3/12/26 at 9:10 AM, V18 (Medical Director) said if a resident is found down CPR should be initiated immediately if there is a delay in CPR it can result in a poor outcome for the patient. The facility provided list of Active CPR certified staff show V3, V5 and V6 are all currently active and certified to perform CPR. The facility provided CPR policy last revised 4/28/25 shows that when a resident has designated their wishes to be a full code it should be honored. The policy additionally shows that if a resident is found down, unresponsive without a pulse, a licensed staff person should initiate CPR immediately to increase their chances of survival. R96's death certificate shows his cause of death on 2/14/26 was pneumonia. (A)			S9999			