

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2023
--	---	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTYVILLE MANOR EXT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 610 PETERSON ROAD LIBERTYVILLE, IL 60048
---	--

(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) COMPLETE DATE
S 000	Initial Comments	S 000		
S9999	<p>Complaint Investigation 2311646/IL156893</p> <p>Final Observations</p> <p>Statement of Licensure Violations:</p> <p>300.610 a) 300.1210 b) 300.1210 c) 300.1210 d)6)</p> <p>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.</p> <p>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.</p>	S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTYVILLE MANOR EXT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 610 PETERSON ROAD LIBERTYVILLE, IL 60048
--	--

(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) COMPLETE DATE
S9999	<p>Continued From page 1</p> <p>c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>These requirements are not met as evidenced by:</p> <p>Based on interview and record review the facility failed to ensure a resident with dementia, a history of falls, and dysphagia was supervised in the dining room, to prevent falls on 1/4/23 and 1/5/23.</p> <p>This applies to 1 of 3 residents (R1) reviewed for safety and supervision in the sample of 5.</p> <p>The findings include:</p> <p>R1's electronic medical record shows her diagnoses to include: Pneumonitis due to inhalation of food and vomit, weakness, rheumatoid and osteoarthritis, displaced fracture of the left humerous, dementia, dysphagia, and a history of TIA (Transient Ischemic Attack).</p> <p>R1's 5/19/21 Care Plan shows she has a diagnosis of dysphagia, (difficulty swallowing) and should be monitored during meal times. The</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2023
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LIBERTYVILLE MANOR EXT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 610 PETERSON ROAD LIBERTYVILLE, IL 60048
--	--

(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) COMPLETE DATE
S9999	<p>Continued From page 2</p> <p>same Care Plan shows R1 is a fall risk related to weakness, unsteady gait, and vision deficits. The goal is keep R1 fall and injury free by visually monitoring an assessing behaviors, and to anticipate factors that caused prior falls.</p> <p>R1's 1/4/23 Unusual Occurrence Report shows at 6:25 PM, R1 was found on the floor, in the dining room, in front of her wheelchair, sitting on her buttocks. No injuries noted. No witnesses noted.</p> <p>R1's 1/5/23 Unusual Occurrence Report shows at 6:00 PM, R1 was found on the floor, in the dining room, laying on her back. The same document shows a CNA (Certified Nursing Assistant) heard the resident's head hit the floor. No witnesses noted.</p> <p>On 3/3/23 at 1:56 PM, V6 IP (Infection Preventionist), QA (Quality Assurance), RN (Registered Nurse) said, it is her job to look at the incident reports, and nurses notes to determine the contributing factors to a resident's fall. V6 said, "(R1) has poor truck control, so she should not be left unattended in the dining room, especially since she slid out of the chair on 1/4/23. (R1) has 2 chairs in her room, a wheelchair and a transport chair. V6 said she believes an agency CNA put R1 in the transport chair instead of her (R1's) wheelchair.</p> <p>On 3/2/23 at 10:30 AM, V2, DON (Director of Nursing), said, "The transport chair is higher than a wheelchair, and (R1) tries to touch her feet to the floor, and so will slide down to get her feet to touch." V2 said she was here in the building on 1/5/23 and heard the commotion, and went to the dining room to see what happened. V2 said R1 was laying on her back on the floor. V2 said she thinks one wheel on the transport chair was</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005359	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/07/2023
--	--	--	---

NAME OF PROVIDER OR SUPPLIER LIBERTYVILLE MANOR EXT CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 610 PETERSON ROAD LIBERTYVILLE, IL 60048
--	--

(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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>locked, and one was not, since the chair rotated to one side. V2 said the facility sent R1 to the hospital the next day (1/6/23) because R1 is on blood thinners and has osteoporosis. V6 said an X-ray showed a right rib fracture, but it couldn't be determined that it happened because of the fall. V6 said R1 was admitted with multiple rib fractures. V6 said R1 should have been taken to an area where she could be closely monitored, especially since R1 is at a higher risk.</p> <p>On 3/3/23 at 1:45 PM, V10 (Spouse of a resident and witness to both of R1's falls) said he is here for all three meals every day. V10 said R1 fell at the dinner meal on 1/4/23 and 1/5/23. V10 said both times R1 fell she was by herself with no supervision.</p> <p>The 2/28/17 Fall Risk Assessment Policy and Procedure shows its purpose is to identify residents that are at risk for falls by providing the necessary assessment, planning, and interventions to be put in place to minimize the risk for falls. The Procedure shows, 2 once a resident is identified as a risk for falling, an appropriate plan of care should be established and individualized for the resident, and 4 the resident should be monitored and assessed to evaluate interventions and to determine if they are appropriate and if changes are necessary.</p> <p>(C)</p>	S9999		