PRINTED: 11/08/2021 **FORM APPROVED** 

Illinois Department of Public Health						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PEAR OF CORRECTION			A. BUILDING:			
IL6005359		B. WING		10/1	; 4/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTY	VILLE MANOR EXT (	610 PFTE	RSON ROA			
LIBERII	VILLE WARON EXT	LIBERTY	VILLE, IL 60	048		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			8
	Facility Reported In IL138991	cident of September 17, 2021				(8)
S9999	Final Observations		S9999			
:	Statement of Licens	sure Violations:				
	300.1210 b) 300.1210 d)3) 300.1210 d)6) 300.3240 a)					
	Nursing and Person b) The facility care and services to practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	shall provide the necessary of attain or maintain the highest of attain or maintain the highest of a strength of the highest of the hig				
	d) Pursuant to nursing care shall in following and shall is seven-day-a-week in 3) Objective a resident's conditional changes, determining care refurther medical evaluation	subsection (a), general nclude, at a minimum, the be practiced on a 24-hour, basis: we observations of changes in on, including mental and as a means for analyzing and equired and the need for luation and treatment shall be aff and recorded in the				22
	taken to assure tha remains as free of a	essary precautions shall be t the residents' environment accident hazards as possible. el shall evaluate residents to		Attachment A Statement of Licensure Violation	s	

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

6899

1DKZ11

TITLE

(X6) DATE

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		IL6005359	B. WING			C 10/14/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
LIBERTY	LIBERTYVILLE MANOR EXT CARE  610 PETERSON ROAD LIBERTYVILLE, IL 60048						
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	see that each resident receives adequate supervision and assistance to prevent accidents.					:	
		Abuse and Neglect icensee, administrator, of a facility shall not abuse or					
	These requirement	s are not met as evidenced by:		Va			
	review, the facility facility facility facility during care.	ion, interview, and record ailed to ensure resident's This failure resulted in R1 comminuted supracondylar al left humerus.					
	shows R1 is a hosp dementia. The san	d, accessed on 10/13/21, bice resident with diagnosis of ne document shows R1 is an ssist with bed mobility and					
Vi	report, dated 9/17/2 Friday 9/17/21 [R1] emergency room for swollen -deformed/ direct involvement if and asked if anything their shift? No one If care, no one notice the elbow until Fridat afternoon 9/17/21 at daughter telephone that R1's left arm w	ed Incident initial and final 21, shows "Outcome: On was sent to the local or evaluation regarding a dislocated elbow. All staff with in R1's care were interviewed ing unusual occurred during had any difficulty with resident d any swelling or deformity to ay (9/17/21). On Friday at approximately 2PM. R1's ad [R1's nurse] and reported as positive for fracture."					
	R1's emergency pro	ogress notes, dated 9/17/21,					

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	IL6005359		B. WING			C 10/14/2021	
	PROVIDER OR SUPPLIER	CARE 610 PETE	DDRESS, CITY, STATE, ZIP CODE  ERSON ROAD  (VILLE, IL 60048				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
S9999	the nursing home for She seems to have touched. She is de history. According it she did not fall or all R1's radiology reported. R1's radiology reported distal humerus left.  R1's CT scan result dated 9/17/21, show humerus  R1's emergency distincted R1's familiany surgical interveback to the facility warm pending orthop.  R1 was seen by orthwith diagnosis of confracture of left humed documents R1's familiany surgical with longer to treat R1's left arm was applied with longer and elevation with the confidence of left humed documents R1's familiand elevation with the confidence of left humed documents R1's left arm was applied with longer and elevation with the confidence of left humed documents R1's left arm was applied with longer and had a longer to R1's hand. It is pillow and had a longer to R1's hand. It is	A-year old who was sent from or evaluation of swollen elbow. pain when the elbow is mented and cannot offer any to the nursing home they feel t least none was documented. It is upper left extremity, was a source of the sof R1's upper left extremity, was a source of the sof R1's upper left extremity, was a source of the sof R1's upper left extremity, was a source of the sof R1's upper left extremity, was a source of the solid part of the sol	\$9999				
	Nurse-LPN) said V3	AM, V3 (License Practical B was R1's nurse on 9/17/21 A was informed by V4 (R1's					

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10/14/2021

Illinois Department of Public Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ C B. WING \_

IL6005359

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

610 PETERSON ROAD

I IRERTYVII I E MANOR EXT CARE		RSON ROAD /ILLE, 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	Continued From page 3	S9999		
	CNA) R1 was complaining of severe pain to R1's left upper arm during morning care. V3 (LPN) said V3 went to check R1's left arm. V3 said R1's arm was swollen, R1 was screaming out in pain when R1's left elbow was touched. V3 said V3 notified V11 (R1's physician) and received an order to send R1 to the emergency room for evaluation. V3 said V3 also informed R1's family. V3 said V3 does not know what happened. V3 said R1 did not fall. V3 said later, V3 learned R1 had a fracture to R1's left arm.			
	On 10/13/21 at 11:10 AM, V4 (CNA) said V4 came to work at 6AM on 9/17/21, and went to check R1 at around 7:30 AM to provide morning care. V4 said V4 asked R1 if R1 can turn to R1's left side. R1 said R1 can't, R1 said R1's left arm hurt so badly. V4 said V4 checked R1's left arm; it was huge and very swollen. V4 said V4 reported to V3 (LPN) right away. V4 said R1 is total care. If R1 fell, R1 needed help to get up from the floor. V4 said V4 was not aware of R1 having any falls.			
	On 10/13/21 at 10:39 AM, V5 (Nurse Unit Manager) said V3 (LPN) informed V5 R1's left arm was swollen. V5 said she went to assess R1. R1's left upper arm was huge, above elbow bend, "it felt like a bone was protruding." V5 said R1's physician was notified, and R1 was sent to the ER for evaluation. R1 was diagnosed with fracture. V5 said V5 interviewed all the staff that took care of R1. No falls of R1 was reported. R1 is total care on transfers, R1 is wheelchair bound and in need of extensive to total assist with bed mobility and transfers. V5 said R1 is unable to tell what happened to R1's left arm; R1 has dementia.			
	On 10/17/21 at 11:30 AM, V6 (LPN) said V6 was			

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origin.

On 10/17/21 at 2:00 PM, V1 (Assistant Administrator) said the facility was unable to determine the cause of R1's left arm fracture/injury. V1 said it was indeed an injury of unknown

On 10/18/21 at 11 AM, V7 (Orthopedic Surgeon) said when V7 saw R1 in his office, R1's fracture was so painful R1 was able to communicate pain, "Oh my God, it hurts so much". V7 said V7 had

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NAME OF	PROVIDER OR SUPPLIER		10/14/2021			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  LIBERTYVILLE MANOR EXT CARE  610 PETERSON ROAD					
LIDER		LIBERTY	/ILLE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 5	S9999			
	knows through V7's fracture was cause	c Doctor since 1999, and s expertise R1's left arm d by a high impact energy, a rce. R1's left arm fracture is				
	(B)					
	8					

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