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	IL6005359	A. BUILDING: _____ B. WING _____	C 10/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 Facility Reported Incident of September 25, 2023 IL166260	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.1010 h) 300.1210 b) 300.1210 d)6) 300.1220 b)2) 300.1220 b)3) 300.2900 d)2) 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 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. 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: 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.	S9999		

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S9999	Continued From page 2 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.2900 General Building Requirements d) Doors and Windows 2) All exterior doors shall be equipped with a signal that will alert the staff if a resident leaves the building. Any exterior door that is supervised during certain periods may have a disconnect device for part-time use. If there is constant 24 hour a day supervision of the door, a signal is not required These requirements are not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident who is at high risk for falls, with diagnoses of dementia, anxiety, subdural hemorrhage and a history of wandering, did not leave the facility unsupervised; failed to have a system in place to assess new admissions for elopement risk; failed to implement interventions to prevent elopement; and failed to ensure all exit doors were secured to prevent an elopement. These failures affected 3	S9999		

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S9999	Continued From page 3 residents (R1, R2, and R3) reviewed for elopement. This failure resulted in R1 eloping from the facility after 6:30 PM on 9/25/23; R1was found at approximately 7:10 PM on 9/25/23 by V8 (Registered Nurse) standing behind her wheelchair in the parking lot, with blood coming from the back of her head. The findings include: 1. R1's Hospital Notes, dated 8/20/23, shows R1 has a diagnoses of: dementia, depression/anxiety, and acute onset subacute subdural hemorrhage. R1's Minimum Data Set Assessment (MDS), dated 8/29/23, shows admitted to the facility on 8/25/23, has diagnoses of: dementia, anxiety, traumatic subdural hemorrhage and altered mental status. This same MDS shows her short and long term memory is impaired, is inattentive, has disorganized thinking and is not steady with walking but able to stabilize without staff assistance and uses a walker and wheelchair. R1's Nursing Notes, dated 8/25/23, shows, "Resident is A/O (alert and oriented) x 1, disoriented to place and time .... Resident is able to stand and ambulate, unsteady weak gait, high fall risk ...Safety measures in place ...." R1's Nursing Notes, dated 9/5/23, shows, "Resident is A/O x 1, disoriented to situation and time. Resident is aware that she is not at home will often state that she is going home tomorrow with her daughter, which is not true ... ... resident will just stand up from wheelchair and try to walk somewhere without asking for assistance." R1's Nursing Notes, dated 9/13/23, shows, "Resident	S9999		

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S9999	Continued From page 4	S9999		

was notably agitated during and after dinner, wanted to call her daughter to come pick her up, resident kept stating that she wanted to go home now." R1's Nursing Notes from 9/23/23 shows she was agitated and kept asking to go home, standing up from her wheelchair and trying to step over footrests, climbed out of recliner chair from side of recliner and refused her medications. R1's Nursing Notes from 8/25/23-9/25/23 document multiple occurrences of R1 being agitated and trying to get up from her wheelchair.

R1's Initial Psychiatric Evaluation, dated 9/21/23, shows, "She has been experiencing episodes of irritability and confusion, accompanied by restlessness ....Despite having a walker and other assistive devices, she has been neglecting to use them during ambulation, increasing her risk for falls and related injuries ...Positive for: inattention, irritability, anxiety, impulsivity ...Judgement: limited ...Insight: limited ...Short term memory: impaired .....Monitor for safety and compliance."

R1's Facility Incident Report, dated 10/3/23, shows on 9/25/23 at 6:30 PM, R1 was last seen sitting at the nurse's station table. At approximately 7:00 PM, V14 (R1's daughter) came to visit R1, and R1 could not be located. At 7:10 PM, R1 was discovered in the north end parking lot, pushing her wheelchair. R1 had an unwitnessed fall that resulted in a cut to the back of her head, with minimal/moderate amount of bleeding and a bump to the back of her head. R1 was sent to the hospital, and re-admitted to the facility on 9/29/23.

R1's Nursing Notes, dated 9/25/23 at 7:36 PM, shows, "Pt (patient) was very agitated and very hard to redirect. She was wandering and was blood (sic) with blood in her hair. She had fallen

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S9999	Continued From page 5 and hit her head there was a laceration on the back of head. When she was brought back onto the unit writer attempted to wash her hair to examine it ... ...I did see a hematoma on the back of head with a laceration. Writer called 911 and sent her to er (emergency room) ...." R1's Head CT Scan Report from 9/25/23 shows, "bilateral cerebral subdural hematomas have increased in size and decreased in density (or are possibly new) compared to 8/15/2023 and are most consistent with subacute hematomas ...Right posterior parietal scalp hematoma." R1's Head CT Scan Report from 9/26/23 shows, "Slight increased volume bilateral holohemispheric subdural fluid collections, possibly representing subacute hemorrhage." R1's Nursing Notes dated 9/29/23 at 3:34 PM shows, "Resident received via ambulance .... Resident is being admitted with [Hospice] care .... Resident had a dose of morphine this AM at hospital due to pain in head and neck ..." R1's Nursing Notes dated 10/4/23 at 7:51 PM shows, "Resident at nurse's station in her brodachair (high back wheelchair), constantly trying to get out of her chair. Confuse and easily agitated. Needs constant monitoring .... Impulsive behavior at times." R1's Nursing Notes dated 10/7/23 shows, "Resident at nurse's station in (specialized wheelchair). Restless and getting agitated ...." R1's Nursing Notes dated 10/9/23 at 10:37 PM shows, "Resident is restless when awake, can get agitated ... . By 4 PM resident is restless again, attempts to get up on her own, no safety awareness, impulsive ...." R1's Care Plan dated 10/10/23 does not document that she is at risk for elopement.	S9999		

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S9999	Continued From page 6 R1's Elopement Risk Assessment, completed on 10/11/12, shows an "x" under the yes column of the below categories: 1. Have diagnosis of dementia, alzheimer's/confusion; 2. Able to be independently mobile; 3. Pace, wander, trying to get out door, find family or friend, perceive they need to be doing something other than what they are doing; 4. Exhibit signs of sundowners; 5. Have a history of elopement/wandering off, getting lost, etc.; 6. Not readily accept nursing home placement. The form states, "If you answered yes to one or more of the above questions, the resident may be at risk. If the score is 5 or greater, they are at risk." R1 had 6 questions marked as "yes". No additional Elopement Risk assessments were found in R1's clinical record. On 10/10/23 at 9:15 AM, R1 was sitting at a table at the nurse' station in a high back wheelchair. R1 appeared agitated and was trying to get up from her wheelchair. R1 was unable to answer questions. R1 did not have a (electronic monitoring device) in place. On 10/10/23 at 3:04 PM, V6 (Certified Nursing Assistant/CNA) said she was familiar with R1. V6 said R1 would frequently try and wander around in her wheelchair, but she was at risk for falls, so the staff would constantly watch her to make sure she did not try and get up and fall. V6 said, "(R1) is usually sitting at the nurse's station table where there is a nurse or CNA present at all times. (R1) frequently talked about leaving the facility or wanting to see her daughter. On the day of the incident, (R1) was wandering a lot, and was very agitated. (R1) started yelling at her during the dinner meal because she wanted to see her daughter and wanted to "get out of here". After dinner, (R1) was brought to the table at the	S9999		

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S9999	Continued From page 7 nurse's station." V6 said she started putting a resident to bed around 6:15 PM, and R1 was sitting at the nurse's station table with V7 (Licensed Practical Nurse) present. V6 said she had to re-direct R1 back to the nurse's station a couple of times while she was putting residents to bed. V6 said R1 was independently propelling her wheelchair down the hallway. On 10/10/23 at 9:58 AM, V7 (Licensed Practical Nurse) said she was familiar with R1 on the date of the incident. V7 said, "She was constantly trying to get up and was saying that she wanted to see her daughter. I would reassure her that her daughter was coming. (R1) was brought to the table by the nurse's station after dinner and was sitting with another resident. Around 6:30 PM, she started passing medications to other residents, while (R1) was sitting at the nurse's station." V7 said she does not remember what time it was that she did not see R1 at the nurse's station table any longer. V7 said, "Around 7:00 PM, (V14, R1's daughter) came to the nurse's station and said (R1) was not in her room, and questioned where she was. At that time, the facility immediately started searching for (R1)." V7 said R1 was found outside, and when they had brought her back in, she had blood coming from the back of her head and said, "I fell, I fell." On 10/10/23 at 3:10 PM, V8 (Registered Nurse) said she heard R1 was missing, so she started searching for her. V8 said when she came to a certain area in the facility, she could hear a faint alarm going off that sounded like a wheelchair alarm. V8 said she immediately went and grabbed the 300 Unit patio door key and unlocked the door. V8 said she does not know if the door was unlocked or locked at that time, since she was so frantic. V8 said she did not	S9999		

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S9999	Continued From page 8 check to see if the door was locked before putting the key in the door; she just put the key in the door and twisted the key around. V8 said there were no door alarms going off at that time. V8 said she could see R1 standing behind her wheelchair in the parking lot (270 feet away from the 300 Unit patio door at the back of the facility), and could hear her wheelchair alarm sounding. On 10/10/23 at 1:03 PM, V15 (R1's Son-in-Law) said he came to visit R1 on 9/25/23, and she was outside near the 300 Unit patio door with other residents and staff. V15 said the door was propped open. V15 said eventually all the staff and residents went back inside, but he stayed out there with R1. V15 said another resident walked out of the door and sat down in the patio area. V15 said a short time later, V3 (Unit Manager) came out and told the other resident he needed to go back inside, and shut the patio door. V15 said he took R1 around the building for a walk and then returned through the unlocked/unarmed 300 unit patio door. V15 said R1 was very agitated that day, and wanted to go see her husband who has passed away. V15 said R1 has been agitated and wanting to leave for quite some time. V15 said on 10/8/23, R1 was discussing with him an escape plan. V15 said R1 stated, "Once that person leaves (talking about an aide), grab her (another resident) and me and we can leave." On 10/10/23 at 9:28 AM, V3 (300 Unit Manager/Licensed Practical Nurse) said, "(R1) has 'sundowners' and gets more agitated and anxious in the evening. (R1) would try to get up and leave the nurse's station frequently, and needed to be watched at all times while she was out of bed, due to her behaviors. (R1) was able to self-propel her wheelchair before the incident	S9999		

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S9999	Continued From page 9 on 9/25/23. The 300 Unit patio door is used by staff or families to take residents outside. The key to the door is hanging in the 300 unit nurse's station. If the door is unlocked, the alarm does not sound when it is opened. If family wants to visit outside on the patio area, the door is unlocked, and it is locked back up again once they return from outside." On 10/12/23 at 9:30 AM, V3 said R1 still tries to get up from her high back wheelchair, and can swing her legs over this side of the chair to try and get up. V3 said R1 still does not have a (electronic monitoring device) on. On 10/11/23 at 10:06 AM, V2 (Director of Nursing) said, "The facility does not assess residents for risk for elopement upon admission." A resident would be considered at risk for elopement if they had the following characteristics: able to ambulate or self-propel their wheelchair, have dementia, trying to leave the facility or always talking about wanting to go home or leave, actively looking for exits, or a history of eloping. V2 said the nurses should actively be monitoring for any of the above behaviors, and immediately notifying the physician if they are having them. V2 said she thinks R1 exited on 9/25/23 through the front door of the facility (less than 300 feet from a 4-lane major highway and 815 feet from where she was found). V2 said there is a code that needs to be entered to open the door, but she may have gotten out after someone left or came in the door. V2 said, "All staff and visitors are aware of the code to open the front door. The only other door that she could have exited was the 300 Unit patio door if it was left unlocked/unarmed. The 300 unit patio door is used to take residents outside when the weather is nice, and it is the responsibility of the staff to unlock the door and lock it back up	S9999		

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when they are not outside. The door will not alarm if the door is unlocked." V2 said when she interviewed all the staff during her investigation, no one said they heard a door alarm going off. V2 said she is not sure if anyone checks the doors to make sure they are secured and the alarms are functioning. V2 said, "(R1's) elopement could have been prevented. (R1) was supposed to have been constantly supervised if she was not in bed or with her family, due to her high risk for falls and she was not."

On 10/11/23 at 11:00 AM, V1 (Administrator) said the facility should always be secured. V1 said, "All doors are alarmed besides the 300 Unit and 400 Unit front door. Those doors have a keypad in place that will open the door once the code is entered. All staff know the code to the doors, as well as all visitors. The code is given to family members in the resident's welcome packet upon admission. Those doors have a (electronic mointoring device) system in place that will alarm if a resident who is wearing a (electronic monitoring device) gets close to the doors, but we have not used the system in years."

On 10/10/23 at 2:43 PM, V11 (Maintenance) said all doors besides the main entrance doors should be alarmed at all times. V11 said the only way the doors would not alarm if opened is if the alarm was turned off and the door unlocked. V11 said he checks to make sure the alarms active and working yearly.

On 10/10/23, V6 (Certified Nursing Assistant/CNA), V7 (Licensed Practical Nurse/LPN), V8 (Registered Nurse.RN), and V9 (CNA) all said they did not hear any door alarms going off on 9/25/23.

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S9999	Continued From page 11 On 10/11/23 at 11:05 AM, V12 (R1's Physician and Medical Director) said he was not aware R1 had eloped from the facility. V12 said that is something that he should have been made aware of. V12 said a demented resident should not be able to exit the facility unattended. V1 said the facility has (electronic monitoring devices), secured doors with alarms, and a code that has to be used at the front door for it to be opened to prevent residents from eloping. 2. R2's Facesheet shows she was admitted to the facility on 3/8/23. R1's Minimum Data Set Asessment (MDS), dated 9/21/23, shows she has short and long term memory problems, inattention, disorganized thinking, wandering that places the resident at risk for getting to potentially danger places and uses a walker and wheelchair. On 10/10/23 at 9:15 AM, R2 was sitting at the nurse's station holding a baby doll. R2 was in a wheelchair. R2 did not have a (electronic monitoring device) in place. On 10/12/23 at 9:20 AM, R2 was sitting at the nurse's station and did not have a (electronic monitoring device) on. On 10/11/23 at 2:42 PM, V3 (300 Unit Manager) said R2 has advanced dementia, and is able to self propel her wheelchair. V3 said R2 does try and wander throughout the facility and is at risk for elopement. V3 said R2 does not have a (electronic monitoring device) on. R2's Elopement Risk Assessment, completed on 10/11/12, shows an "x" under the yes column of the below categories: 1. Have diagnosis of dementia, alzheimer's/confusion; 2. Able to be	S9999		

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S9999	Continued From page 12	S9999		

independently mobile; 3. Pace, wander, trying to get out door, find family or friend, perceive they need to be doing something other than what they are doing; 5. Have a history of elopement/wandering off, getting lost, etc.; The form states, "If you answered yes to one or more of the above questions, the resident may be at risk. If the score is 5 or greater, they are at risk." R2 had 4 questions marked as "yes". No additional Elopement Risk assessments were found in R2's clinical record.

R2's Care Plan, printed on 10/11/23, does not document she is at risk for elopement.

3. R3's Facesheet shows she was re-admitted to the facility on 9/18/23.

R3's Minimum Data Set Assessment (MDS), dated 9/22/23, shows her cognition is impaired and uses a walker and wheelchair.

On 10/12/23 at 9:05 AM, R3 was sitting in bed eating breakfast. R3 said she has been at the facility for one year and hates it. R3 said she does not want to be at the facility and wants to go home. R3 said she is able to move throughout the facility in her wheelchair. R3 did not have a (electronic monitoring device) on.

On 10/11/23 at 2:00 PM, V17 (Physical Therapist) said R3 is able to self-propel her wheelchair, and would be able to open doors. V17 stated, "I just saw her wheeling herself in her wheelchair in the hallway."

On 10/11/23 at 2:42 PM, V3 (300 Unit Manager) said R3 is confused and has the ability to leave the facility. V3 said R3 will say she wants to go home, but thinks her father is keeping her at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005359	A. BUILDING: _____ B. WING _____	C 10/20/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 13 facility. V3 said R3 does not have a (electronic monitoring device) on. R3's Nursing Notes, dated 9/27/23, shows, "Resident A/O (alert and oriented) x 2, disoriented to time and situation. Resident is confused and often refers to husband as her father, resident often refers to her brother and sister living at home with her father. Resident is easily agitated.....Resident asked this writer when she would be able to go home, this writer explained that she would needed to be stronger.....resident stated that "everyone keeps saying that but I don't see what you are talking about".....Resident also stated that she was able to walk home from here and that if she could prove it." R3's Nursing Notes dated 9/23/23 show, "Resident noted to be confused this shift, resident stated she was going to get up and go to church, when asked how she was going to get there, she stated, "in my car, I'm a big girl." R3's Elopement Risk Assessment, completed on 10/11/12, shows an "x" under the yes column of the below categories: 1. Have diagnosis of dementia, alzheimer's/confusion; 2. Able to be independently mobile; 6. Not readily accepting of nursing home placement. The form states, "If you answered yes to one or more of the above questions, the resident may be at risk. If the score is 5 or greater, they are at risk." R3 had 3 questions marked as "yes". No additional Elopement Risk assessments were found in R3's clinical record. R3's Care Plan, printed on 10/11/23, does not document she is at risk for elopement. The facility's undated/untitled Policy shows, "It is the policy of [facility] to ensure the safety of our	S9999		

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S9999	Continued From page 14 residents at all times. Residents that are assessed as an elopement risk shall have a wander guard applied on their ankle to alert staff if resident is nearing an east and/or west front door." The facility's undated Code Alert Policy shows, "It is the responsibility of every employee at [facility] to respond to the Code Alert notification system and the emergency exit door alarms ....The Code Alert notification system will sound off when a resident with a wander guard approaches the east and west entrance/exit doors to the facility .....The emergency exit door alarms will sound off when a resident has opened a door in the hallways or in the great room. All staff members should respond to this alarm." On 10/11/23 at 11:00 AM, V1 (Administrator) said they do not have a specific policy regarding ensuring the exit doors remained alarmed and that they are checked routinely to ensure they are working. (A)	S9999		