(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6005359	B. WING		01/2	21/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTY	VILLE MANOR EXT	CARE	RSON ROAI VILLE, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	Annual Licensure S	Survey				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610 a) 300.1210 b) 300.1210 d)3) 300.1220 b)2) 300.1220 b)7)					

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/06/25 **Electronically Signed**

TITLE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	IL6005359		B. WING		01/21/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
LIBERTY	VILLE MANOR EXT (CARE 610 PETE	RSON ROAD			
LIDEIXI	VILLE MANOR EXT	LIBERTY	/ILLE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 1	S9999			
	d) Pursuant to nursing care shall in following and shall is seven-day-a-week 3) Objective a resident's conditional changes determining care refurther medical evant made by nursing stresident's medical resident's medical resident services by Overseassessment of the include medically defunctional status, se impairments, nutritices potential, cognitive 7) Coordin	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				
	These requirements	s are not met as evidenced by:				
	review, the facility factor monitor residents loss, including a resign gastrostomy tube (0 physician ordered v (R183, R135, R10, resident's decrease this resident's curre	on, interview, and record ailed to have a system in place is (R135, R10, R86) for weight sident (R183) with a G-Tube); failed to ensure weights were performed R86); failed to report a ed oral intake and obtain/report ent weight to the physician ing this resident's (R183)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		IL6005359	B. WING			21/2025
	PROVIDER OR SUPPLIER	CARE 610 PETE	DRESS, CITY, ST RSON ROAD /ILLE, IL 600			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	enteral feeding; fail Dietician that a resi were discontinued; interventions were intake prior to disco (R183). These failu (R183, R135, R10, in the sample of 12 R183 sustaining a videspite having a gaplace. The findings include 1. R183's hospital r 2024 to November admitted to the hos	ed to notify the Registered dent's (R183) enteral feedings and failed to ensure in place to maintain nutritional ontinuing an enteral feeding ures apply to 4 of 9 residents R86) reviewed for weight loss. These failures resulted in weight loss of 3.3% in 41 days astrostomy tube (G-Tube) in	S9999			
	R183 had surgery t September 30, 202 also had diagnoses polyneuropathy, alto protein-calorie malr infection), esophag During R183's hosp (G-Tube) was place feedings, due to he hospital records als delayed-healing to The records showe local skilled nursing 2024. R183's admission r 2024, showed R183 from another local s R183's physician di dated December 5,	o repair her left hip fracture on 4. The records showed R183 of alcohol abuse, alcoholic				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	IL6005359		B. WING		01/2	1/2025
LIBERTYVILLE MANOR EXT CARE			DRESS, CITY, S RSON ROAL /ILLE, IL 60			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
\$9999	weighed once a day R183's discharge w December 5, 2024. showed R183 was orally, but was to al enteral feedings via the day, for nutrition R183's December 2 Report showed R18 December 5, 2024, The report showed R183 from December 2025. R183's nursing note December 5, 2024 multiple entries of F intake/appetite and R183's medical rec to January 14, 2029 staff monitoring and intake. R183's Dietary Note showed she was se showed R183's "ap been poor." The no added an order for for R183 at night; J feeding/nutritional s (cubic centimeters due to R183's poor showed, "RD (Regi to add nocturnal feed intake during day ti to new enteral feed improvement in ora	y. The records showed reight as 154 pounds (lbs) on The discharge orders prescribed a regular diet to eat so receive supplemental bolus a G-Tube, every 4 hours during	S9999			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		IL6005359	B. WING		01/2	21/2025
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
I IBERTYVII I E MANOR EXT CARE			TERSON ROA TYVILLE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	nge 4	S9999			
	were discontinued.					
	showed R183's corfeedings were discordings. The order s	dated January 6, 2025, ntinuous nighttime enteral ontinued by V12 (Physician o showed V3, Nurse Manager, r from V12 on January 6, 202 deedings.				
	January 14, 2025 s supplemental enter	cords, dated January 6, 2025 showed R183 received no ral feedings during this time, to have poor-fair oral intake.	to			
	R183's January 2025 Weight Report showed R183 was weighed for the first time in the facility on January 15, 2025 and was 140.2 pounds. R183 was re-weighed on January 16, 2025 and was 149 lbs. This showed R183 sustained a 3.3% weight loss from December 5, 2024 to January 16, 2025 (41 days).		,			
	seated in a high-ba R183 appeared thir R138's gastrostom waist. R138 stated been weighed here was at the old reha weigh me here." W	25 at 12:10 PM, R183 was lick wheelchair in her room. In and slightly jaundiced. It tubing hung down by her last time I was weighed be place. No one has asked about stated, "I don't like the food he ungry."	0			
	Manager, stated sh V12 (Physician of F discontinue R183's family wanted her to V3 stated she was	25 at 10:49 AM, V3, Nurse the got the verbal order from R183) on January 6, 2025 to enteral feedings because "tloo get hungry and eat more." aware of R183's poor-fair spoke with V12 on January 6				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		11 0005350		B WING		
		IL6005359	B. WING		01/2	1/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
I IBERTYVII I E MANOR EXT CARE			RSON ROAD VILLE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
	been weighed until got the order, (V12 on (R183). I didn't anything about her about it. "V3 state Dietician, that R183 discontinued. On January 15, 202 Nursing (DON), corupon admission to unaware R183 had	not been weighed at all in the				
	upon admission to the facility. V4 stated she was unaware R183 had not been weighed at all in the facility until January 15, 2025. V4 stated R183 was not weighed until January 15, 2025 because "someone did not put the physician order for her to be weighed. It got missed when she got admitted. She should have been weighed at least once a week for the first four weeks of her admission. The admitting nurse should have put the order in. Myself and the Dietician are responsible for making sure the weights are done." V4 stated she was aware R183 was no longer receiving enteral feedings, but was not sure how long she had gone without. V4 stated she had not notified V6, Dietician, that R183 had never been weighed in the facility or that R183's enteral feedings had been discontinued. V4 stated she had not notified V6, Dietician, or V12 (Physician of R183) of R183's poor-fair oral intake. V4 stated, "The family wanted the enteral feeding to be stopped to see if she would eat more." V4 stated R183's oral appetite "had not really improved" since discontinuing R183's					
	R183's family R183 the facility. On January 14, 202	4 state she had not notified 3 had never been weighed in 25 at 2:36 PM, V6, Dietician, issions should be weighed				

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AND DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		IL6005359	B. WING		01/2	1/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LIBERT	VILLE MANOR EXT	CARE	RSON ROAD VILLE, IL 60			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	within 24 hours of a the first four weeks was not aware (R18 She should have be When I saw her on her on continuous of because I was condand she had not be weights and monitor. I monitor for weight only at the facility for one called me to le weighed or that her On January 15, 202 was asked if she had feedings had been weights from January astated, "No one tolchad been discontinuous to let me know she they were consider feedings, I would had been aware coloss, I would have discontinue her feeding order on January 16, 202 of R183) stated he feeding order on Jafamily requested, his she had never been intake had continuous R183 should have upon admission to known R183's appoint that she had not be with the same that the sam	admission and once a week for of admission. V6 stated, "I 83) was not being weighed. Been weighed once a week. December 9, 2024, I started enteral feedings at night cerned about her losing weight been eating much. Checking oring oral intakes are ways that a loss. I am contracted so I am or eight hours a month. No to me know she had not been appetite had not improved." 25 at 11:21 AM, V6, Dietician, and been notified R183's enteral discontinued and/or of R183's ary 4 to January 15, 2025. V6 at me her (enteral) feedings ued. Why? No one has called lost weight. If I had known ing stopping her enteral ave come in to assess her, get and review her oral intakes. If of her poor appetite and weight recommended to not	\$9999			

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STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6005359	B. WING		01/2	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTY	VILLE MANOR EXT O	CARF	RSON ROAD (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 SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 7	S9999			
	R183) stated she had not been weighed in knew she wasn't ear to stop her other feet more, but I did not wher. No one has called had not improved so the she is not hospice, better to get her how the facility on December (Parameter) and provided in the shadow of the she was a state of the she was a	et shows she was admitted to mber 17, 2024. ords shows she weighed 132 cember 14, 2024 in the				
	The facility did not weigh R135 on admission. The first weight done in the facility was on January 9, 2025 (23 days after admission). R135's weight was 119.4 lbs. (13 lb weight loss in 23 days). On January 16, 2025 at 10:57 AM, V4, Director of Nursing, stated R135's weight was not done because she was on contact isolation when she was admitted to the facility.					
	3. R10's face sheethe facility on Decer	t shows she was admitted to mber 20, 2024.				
	R10 was not weight days later).	ed until January 1, 2025 (12				
	4. R86's face shee the facility on Decer	t shows, she was admitted to mber 12, 2024.				

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R86 was not weighed until January 3, 2025 (22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUI COMPLET				
		IL6005359	B. WING		01/2	1/2025
	PROVIDER OR SUPPLIER	610 PETE	RESS, CITY, S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	days later). On January 16, 202 Nursing, stated weige admission. The facility's Weigh February 26, 2024, policy is to assess to maintenance of each accomplished through allow the facility to residual weight Each residual admission. Medical weekly, every Mondweighed on admission.	t Maintenance policy, dated showed, "The purpose of this he proper nutrition and weight ch resident. This can be agh a weight schedule that will monitor any changes in lent will be weighed on re residents will be weighed lay. Skilled residents will be ion and monthly thereafter given by dietary or the	S9999			

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