(X6) DATE

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		IL6005359	B. WING		02/1	8/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
LIBERTY	VILLE MANOR EXT O	CARE	RSON ROAL			
	LIBERTY					(X5)
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE THE APPROPRIATE	
S 000	Initial Comments		S 000			
	Facility Reported In IL186252	cident of February 8, 2025				
S9999	Final Observations		S9999			
	Statement of Licens	sure Violations:				
	300.610 a) 300.1210 b) 300.1210 c) 300.1220 b)3)					
	a) The facility of procedures governing facility. The written be formulated by a Committee consisting administrator, the amedical advisory conformed for any of nursing and othe policies shall complements.	dvisory physician or the ommittee, and representatives r services in the facility. The y with the Act and this Part. shall be followed in operating be reviewed at least annually documented by written, signed				
	Nursing and Persor b) The facility scare and services to practicable physical well-being of the re- each resident's com- plan. Adequate and care and personal of	shall provide the necessary of attain or maintain the highest l, mental, and psychological sident, in accordance with aprehensive resident care properly supervised nursing care shall be provided to each e total nursing and personal				

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

**Electronically Signed** 02/28/25

TITLE

Illinois D	Illinois Department of Public Health					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		IL6005359	B. WING		1	8/2025
NAME OF 1	PROVIDER OR SUPPLIER	OTDEET AD	DRESS CITY O	STATE, ZIP CODE		
NAIVIE OF I	-KOVIDER OR SUPPLIER					
LIBERTY	VILLE MANOR EXT	CARE	RSON ROAI VILLE, IL 60			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
S9999	Continued From pa	ige 1	S9999			
	c) Each direct	care-giving staff shall review				
		able about his or her residents'				
	respective resident	care plan.				
	Section 300 1220 5	Supervision of Nursing				
	Services	Caper violeti or realoning				
		hall supervise and oversee the				
	nursing services of	the facility, including:				
	3) Developing an up-to-date resident					
		resident based on the				
	resident's comprehensive assessment, individual					
		be accomplished, physician's al care and nursing needs.				
		nting other services such as				
		dietary, and such other				
		rdered by the physician, shall				
	be involved in the p	reparation of the resident care				
		ll be in writing and shall be				
		fied in keeping with the care				
		d by the resident's condition.				
	ne pian shall be re months.	eviewed at least every three				
	monuis.					
	These requirements	s are not met as evidenced by:				
		ion, interview, and record				
		ailed to ensure care was				
		e manner while using a and lift for 1 of 3 residents				
		afety in the sample of 3. This				
		21 sustaining a distal femur				
	(lower thigh bone) f					
	The findings include	e:				
	R1's History and Ph	nysical, dated 2/8/25, shows,				
		to the ED (Emergency				
		c/o right leg pain s/p (status				
		being transferred from her				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			B. WING			
IL6005359			B. WING		02/1	8/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTY	LIBERTYVILLE MANOR EXT CARE					
			/ILLE, IL 60		DNI .	()(5)
(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 2	S9999			
	stand" reportedly m patient falling. Pati- fall and was transfe (evaluation). In the "fracture of the distance R1's X-ray of her rig "Displaced and ang	ght knee, dated 2/8/25, shows, julated comminuted fracture of				
	the distal diaphysis of the femur with posterior displacement of the distal fragment by 1.4 cm (centimeters)."					
	R1's Orthopedic Notes, dated 2/8/25, shows, "This is an 83 year old women with dementia nursing home resident. She is wheelchair-bound. While transferring she sustained a fall. She has right leg painright lower extremity is swollen. Tender about knee. Crepitation notedpainful supracondylar femur fracture, rightSurgery scheduled for tomorrow morning" R1's Operative Report shows she had an intramedullary nailing to stabilize her right femur on 2/9/25.					
	she is at risk for fall unsteady gait relate Vascular Accident)	Plan, printed on 2/18/25, shows its related to weakness, and to recent CVA (Cerebral with left sided weakness. R1's document the use of a sit to nical lift.				
	On 2/18/25 at 1:58 PM, R1 was sitting in a wheelchair in her room. R1 had an immobilizer brace on her right leg. R1 was unable to say what had happened to her leg.					
	1200, [V5, Residen	, dated 2/8/25, shows, "At t Attendant] reported to this on the floor in the shower				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
					С	
		IL6005359	B. WING			8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTY	VILLE MANOR EXT (	CARE	RSON ROAD			
	LIBERTY					
(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 SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 3	S9999			
	in distress. CNA (C stated that resident care and stepped of and began to slide resident onto floor. intact, resident yelli distress.Resident a wheelchair] and the x3. In bed, Resident R (right) knee wher swollen. Resident sevaluation."	ssisted to [high back en to bed with [mechanical lift] nt c/o (complained of) pain in n movement and noted to be sent out to [local hospital] for				
	R1's Nursing Notes, dated 2/11/25, shows, "Resident was re-admitted from [local hospital]alert and oriented x 1Resident had surgery due to fracture of the right femur on 2/9. Resident c/o pain during movement"					
	brought R1 into the incontinence care. mechanical sit to st up from her wheelch and pulled her pant fine with the care. Into the wheelchair R1 began slipping wheelchair. V3 said shower room to get wheelchair. V3 said Attendant) and V5 of tried to get her back so V5 called V4 (CI herself could not get they lowered her to (Licensed Practical were strapped onto	O AM, V3 (CNA) said she shower room to provide V3 said she was using the and lift. V3 said she lifted R1 hair and changed her brief s up. V3 said everything went She then went to put her back and as she lowered R1 down, off of the seat of the d she then stepped out of the help to move her back in the d she saw V5 (Resident came in the room and they k into the chair, but could not, NA) to help. V3 said V4 and et R1 back into the chair, so the ground and then got V6 Nurse). V3 said R1's legs the lift, but she undid the rived so they could try and				

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AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
			A. BOILDING.		,	С
		IL6005359	B. WING			18/2025
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET A			STATE, ZIP CODE		
LIBERTYVII LE MANOR EXT CARE			TERSON ROAD TYVILLE, IL 60			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
\$9999	move her back into feet never came of remembers. V3 stawhen asked why shwith the lift once shchair.  On 2/18/25 at 10:50 said she was bringing dining room around the shower room at help her. V5 said v room, R1 was hanging v5 said V3 instruction wheelchair closer, I chair due the foot rishe noticed the left and the right side of she went to try and they could not get himmediately called once V4 entered the bringing residents to she did not pay attellegs when she was on 2/18/25 at 10:00 heard V5 yelling for V4 said R1 was how V4 said R1 was how V4 said R1 was how V4 said R1 was was hat the chair. V5 said I on when she entered when she entered was on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair. V5 said I on when she entered was said R1 was was hat the chair.	o the wheelchair. V3 said R1's of the platform that she lated, "I did not think of that" he did not raise her back up he started to slip out of the late of the chair. V5 has of the late	t) s. ed ce			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BUILDING:		C	
		IL6005359	B. WING			8/2025
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTYVII LE MANOR EXT CARE			RSON ROAD VILLE, IL 60			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
\$9999	her down to the floogot V6 (Licensed P assessment. V4 stathat I had seen behroom."  On 2/18/25 at 11:07 Nurse) said that archer and said they ninto the shower roothe floor. V6 said Vand she began to said V3 said they chair so they lowerd was screaming "Oubreathe. V6 said dibreathe, they transfer mechanical lift. V6 knee seemed swoll touch, so she was evaluation. V6 said had happened, and end up underneath  On 2/18/25 at 11:57 when staff use the ensure the upper slonthe sling tightene body support. V7 sflat on the platform padded leg support strapped in to ensure the wheelchair, raise them up and a set them back down	nhooked the sling and eased or. V4 said she then went and ractical Nurse/LPN) to do an ated, "She hurt the same leg ind her when I came into the I AM, V6 (Licensed Practical bund 12:00 PM, V4 came to eeded her. V6 said she went m and R1 was laying flat on 73 said she was changing her lide off of the sit to stand. V6 buld not put her back on the ed her to the floor. V6 said R1 inch" and saying she could not ue to her not being able to ferred her to bed with a said at that time, her right en and was tender to the sent to the hospital for an I she asked the CNAs what they had said her right leg did	S9999			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION (X3) DATE SURVEY COMPLETED			
		IL6005359	B. WING			C <b>18/2025</b>
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
I IRERTYVII I E MANOR EXT CARE			ERSON ROAD /VILLE, IL 600			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ige 6	S9999			
	said she did the invisal she feels the firm when they lowered when they noticed to into the chair, they help before deciding V2 said their policy needed to use the swould be safer for the staff member present the past she wants	PM, V2 (Director of Nursing) restigation into R1's fall. V2 racture may have occurred her to the ground. V2 said they were not able to get her should have called for more g to lower her to the ground. only states one person is sit to stand, but she feels that it the resident if there were two ent, and had told the staff in them to always use two staff o stand transfers for the	t			
	Maintenance Policy new staff (RN's, LP should review the o instructions for prop liftThe resident's	ne facility's Sit to Stand Operating and aintenance Policy, dated 10/24/24, shows, "All ew staff (RN's, LPN's and CNA's) to the facility nould review the operating and maintenance structions for proper use of the sit to stand tThe resident's feet should always be in ontact with the foot support."				
	shows, "Lower leg spatients if it is deter unable to maintain supportsEnsure comfortable for the	Lift 3000 Inservice packet straps: Can be used to those rmined that the patient is his knees within the knee that the straps are firm but patientThe patient's feet ain in full contact with the foot				
	6/2003, shows, "Po patients back so the horizontally about to waistlineTo faste press the buckles to	User Instructions, dated sition the sling around the at the bottom of the sling lies wo inches above the patients in the support strap securely, ogether. The strap should be ble for the patientThe suppor	t			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
7 1.2 1 2 1	0. 00.11.20.10.1		A. BUILDING:			
	IL6005359		B. WING		02/1	; 8/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LIBERTY	VILLE MANOR EXT (	:ARE	RSON ROAI			
		LIBERTYV	/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 APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
\$9999	strap will help to su during the lifting pro- retains the sling in to patientCarefully p full lower leg contact supportLower Let the lower parts of the the knee support. supports, then arou To fasten, overlap a	pport the patient in the sling ocedure. The strap also the correct position around the ush the left in closer to make	S9999			

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