STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145593	A. BUILDING _____ B. WING _____	C 06/29/2012

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MANORCARE OF LIBERTYVILLE	**1500 SOUTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048**

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F 323	Continued From page 4 have definitely been better if E4 stayed with R1 while I moved the lift out of the way. On 6/29/12 at 12:12PM, E8 (3rd floor PM nurse supervisor), said R1's 6/10/12 fall incident was probably due to her being on an air mattress. E8 said she felt it was all right for E4 to leave R1's room before the lift was removed and R1 was laid down. E8 said she did not think about the possible need for E4 to stay with R1 while E3 was removing the lift until this conversation. On 6/12/12 facility inserviced all nursing staff on "Safety tips on lift transfers". This inservice included Be sure patient is securely positioned in bed/ chair/ toilet before removing lift and sling. Ensure the patient is not on the edge of the bed or chair during positioning. Never turn your back on a patient that has poor trunk control and stability. On 6/29/12 E8 also said prior to R1's 6/10/12 fall, the mechanical lift inservices did not include "safety tips on lift transfers" information . This information will now be included in all future orientation and annual lift inservices. On 6/28/12 R1 observed in bed with yellow colored bruising to right hand 4th finger, middle and left side of forehead and bilateral knees to mid shin area's. R1 complained of continued pain below right knee ever since her 6/10/12 fall. This area had a brownish colored swollen area. R1's mid forehead had a 1.5 - 2 inch lateral healing laceration and a 2 inch lateral healing laceration above the left eyebrow.	F 323		
F9999	FINAL OBSERVATIONS	F9999		

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F9999	Continued From page 5 Final Observations Licensure VIOLATIONS 300.1210b) 300.1210d) 300.1210d)6) 300.3240a) 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.	F9999		

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F9999	Continued From page 6 Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based on observation, record review and interview nursing staff failed to provide adequate supervision and assistance during a transfer activity of one of three sampled residents (R1). This failure resulted in R1 falling to the floor and sustaining multiple facial contusions, facial lacerations requiring suturing, contusion injuries to right hand and bilateral lower extremities and pain. Findings include; The facility incident report for R1 dated 6/10/12 is included: On 6/10/12 at 4:20PM R1 was assisted back to bed using a mechanical (sit to stand) lift and set on the edge of the bed by E3 and E4 (certified nurse assistants). R1's bed contained an air mattress. Immediately after R1 was seated onto the edge of bed and prior to removing the mechanical lift, E4 left E3 alone with R1. After E4 left the room, E3 removed the lift belt straps from R1, turned away from the resident, with her back to R1 while rolling the mechanical lift away from	F9999		

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F9999	Continued From page 7	F9999		

R1's bed. E3 witnessed R1 fall forward off the bed and onto the floor. E3 was unable to reach R1 in time to prevent the fall. R1 sustained facial contusions and lacerations that required suturing and a contused right hand.

This incident report also documents:

"Per investigation, it seems as if resident (R1), was not positioned securely in the center of mattress and was seated at the edge of the bed with her legs dangling. When CNA (E3), turned away, residents poor trunk stability caused her to lean forward and she (R1), slid off bed."

E3's written statement included " Before the fall, patient (R1), was sitting on the left side of the bed with her knees together." " I was removing the lift in order to make room to swing the patients legs on to the bed." "(E4) was present during the actual transfer from wheelchair to bed using the lift. When we were done E4 left and R1 was sitting on the side of the bed in an up-right position, with her right hand holding onto the lift. I told her (R1), to take right hand off lift which she did, so I could move lift out of the way. She (R1), just went straight forward and landed on her head, telephone base ended on floor also, I saw her fall but I was too far away moving lift. I had already removed the sling."

R1's medical record includes:

R1 is a 94 year old resident with diagnosis to include Muscle weakness, gait abnormality, Osteoporosis and Osteoarthritis.

R1's 5/10/2012 minimum data set assessment

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F9999	Continued From page 8 (MDS), includes needs extensive assistance by two or more people with bed mobility, transfers and toileting activities. This assessment also documents no behavioral problems, alert, communicative and with modified independent cognition. This MDS documents R1 weight as 167 pounds. R1's 3/03/2008 fall risk care plan includes at risk for falls due to impaired balance , generalized weakness and history of falls. Interventions document two person assistance with transfers using a mechanical lift. On 6/11/12 the care plans interventions were updated to include "make sure patient is securely positioned in center of mattress when / after transferring to bed. R1's Care plan also includes "Deficits in bed mobility and transfer skills, bed<-->chair, related to complaints of generalized pain and muscle weakness in bilateral upper and lower extremities and deficits in functional sitting and standing balance." R1's 6/11/12 Fall assessment includes : Difficulty maintaining sitting and standing balance, gait problem and muscular-skeletal problem. R1's 6/11/12 physical therapy includes: weakness and decreased coordination and left upper and lower extremity due to history of possible stroke in December 2011, as well as right lower extremity muscle weakness. Requires moderate assist with bed mobility and maximum assist with mechanical lift for transfers. During individual interviews the following	F9999		

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information was obtained:

On 6/28/12 at 11AM, E1 (Administrator), said On 6/10/12 E3 and E4 assisted R1 to bed using mechanical lift. Once R1 was put on the bed, E4 left the room. We think R1 slid off the bed because she was on an air mattress.

On 6/28/12 at 3:00PM, E4 said that on 6/10/12 she assisted E3 to transfer R1 to bed using the mechanical sit to stand lift. After R1 was seated on the bed, E4 left the room to assist other residents. E4 said maybe E3 couldn't get to R1 in time due to the lift being in the way. R1's room is very crowded and E3 could not get to R1 to help her until the lift is moved out of the way. E4 also said maybe she should have stayed with R1 until she was laying in bed, but the nurse aides do not usually do that.

On 6/29/12 at 9:35AM, during a telephone interview, E3 said On 6/10/12 E4 assisted E3 to transfer R1 to bed using the mechanical lift (sit to stand). E4 left the room right after R1 was seated on the bed. After E4 left, I was pulling the mechanical lift out of the way so I could lift R1's legs up on the bed. The space between residents bed and window was very crowded and a wheel chair was also in the way. There are always two nurse aides to transfer residents with mechanical lifts. Once the residents are transferred to bed or chair, the other nurse aide usually leaves the room. R1 has poor sitting balance and it would have definitely been better if E4 stayed with R1 while I moved the lift out of the way.

On 6/29/12 at 12:12PM, E8 (3rd floor PM nurse supervisor), said R1's 6/10/12 fall incident was

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F9999	Continued From page 10 probably due to her being on an air mattress. E8 said she felt it was all right for E4 to leave R1's room before the lift was removed and R1 was laid down. E8 said she did not think about the possible need for E4 to stay with R1 while E3 was removing the lift until this conversation. On 6/12/12 facility inserviced all nursing staff on "Safety tips on lift transfers". This inservice included Be sure patient is securely positioned in bed/ chair/ toilet before removing lift and sling. Ensure the patient is not on the edge of the bed or chair during positioning. Never turn your back on a patient that has poor trunk control and stability. On 6/29/12 E8 also said prior to R1's 6/10/12 fall, the mechanical lift inservices did not include "safety tips on lift transfers" information . This information will now be included in all future orientation and annual lift inservices. On 6/28/12 R1 observed in bed with yellow colored bruising to right hand 4th finger, middle and left side of forehead and bilateral knees to mid shin area's. R1 complained of continued pain below right knee ever since her 6/10/12 fall. This area had a brownish colored swollen area. R1's mid forehead had a 1.5 - 2 inch lateral healing laceration and a 2 inch lateral healing laceration above the left eyebrow. "B"	F9999		