STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F 441	Continued From page 21 On 8/13/13 at 9:35am E15 (Registered Nurse) entered R6 ' s room wearing gloves. E15 positioned the table and other items with these gloves. E15 proceeded to prepare and remove the dirty dressing form R6 ' s buttock without changing the dirty gloves or washing her hands. E15 applied the clean dressing with the contaminated gloves. E15 put the ointments/nystatin powder used for wound care back into the plastic bag with the dirty gloved hands. E15 returned this contaminated plastic bag with the ointments in it back to the drawer of the treatment cart. E15 removed the dirty gloves upon completion of the dressing, and then washed her hands. E15 States, " Oh I should have washed hands, and changed gloves in between. " On 8/13/13 at 2:05pm E19 (Registered Nurse) observed doing wound care to R2 without hand hygiene being performed. E19 completed wound care to the left foot, and right leg of R2 who ' s on isolation without changing her gloves or washing her hands when removing the dirty dressing. E19 used the same gloves that she removed the dirty dressing with to apply the clean dressing. R2 is documented to have MRSA (Methicillin Resistant Staphylococcus Aureus) in her right leg. On 8/13/13 at 2:20pm E15 is observed during incontinent care on R7. E15 removed the soiled incontinent brief from R7, wipe the perineal area with dry tissue, place the soiled tissue on the bed, and then the bedside table. E15 never used water or any perineal cleanser during incontinent care. E15 never clean the contaminated bedside table off after putting the dirty tissue on the table.	F 441		
F9999	FINAL OBSERVATIONS	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F9999	Continued From page 22 LICENSURE VIOLATIONS 300.1210b) 300.1210d)6) 300.1220b)3) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including:	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F9999	Continued From page 23	F9999		

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 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.(Section 2-107 of the Act)

These requirements are not met as evidenced by:

Based on observation, record review, and interview, the facility failed to implement timely and appropriate fall prevention measures and to provide adequate supervision for 1 of 16 residents (R23) reviewed for falls in a sample of 30. These failures resulted in R23 falling and sustaining a laceration to the back of his head, and being transferred to the local hospital where R23 received staples.

Findings include:

R23 was admitted to the facility on 6/20/13 with the following diagnoses: Abnormal gait, muscle weakness, systolic heart failure, physical therapy, dysphagia, speech-language therapy, syncope

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F9999	Continued From page 24	F9999		

and collapse, osteoporosis, lack of coordination, hypertension, depression, altered mental status, dementia with behaviors, and anxiety.

R23 ' s admission MDS (Minimum Data Sheet) dated 6/27/13 documents:
C0100 Should Brief Mental Interview for Mental status -0- (not entered)
C0600 Should the Staff Assessment for Mental Status be conducted- Yes
Short term memory- Memory problem
Long term memory- Memory Problem
Cognitive skills for daily decision making- moderately impaired
D0500 Trouble concentrating on things, such as reading the newspaper or watching television
E0100 Potential indicators of psychosis- delusions
G0110 Transfers- Extensive assistance, 1 person physical assist
Walk in room- Limited assistance, 1 person physical assist
Walk in corridor-Extensive assistance, 1 person physical assist
Locomotion on and off unit- Extensive assistance, 1 person physical assist
Toilet use- Extensive assistance, 1 person physical assist
G0300 Balance during transitions and walking- Not steady, only able to stabilize with staff assistance when moving from seated to standing position, walking, turning around, moving on and off toilet, and surface-to-surface transfer
G0400 Mobility devices- walker, wheelchair
J1700 Falls- no falls any time in the last 6 months prior to admission

R23's Physician's Order Sheet (POS) documents the following medications:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F9999	Continued From page 25	F9999		

Enoxaparin 40mg/0.4ml subcutaneous once daily (anti-coagulant).
Aspirin 81 mg Enteric coated, by mouth daily.

The facility's Fall Incident Reports for R23 documents the following falls: 6/21/13 7/11/13, 7/26/13, 8/3/13, 8/7/13, and 8/11/13. The documented fall reports are listed below.

Fall: 6/21/13 at 2:30am-Location by the bathroom door. Description- noted lying on the floor on his back by the bathroom door.

Fall: 7/11/13 at 9:15pm-Location-resident room
On 8/14/13 at 12:03pm, E13 (Registered Nurse/RN/Resident Care Manager) stated that she was responsible for adding fall interventions for the falls R23 sustained on 7/11/13 and 7/26/13. E13 stated that on 7/11/13, R23 wanted to go to the bathroom and was agitated because staff assisting him was female. E13 stated to the survey team, "his daughter told us, when he came here, that he didn't like females." E13 stated that R23 was resistant when the female staff was trying to toilet him. This according to E13 led to staff sliding him to the floor. When asked what interventions were added, E13 stated, "It was just the fact that we tried to keep him safe." The question was rephrased, and E13 was asked what interventions were placed to prevent this situation from reoccurring. E13 then stated, "he already had alarms and a low bed, but this was for night." E13 was then asked if there were male staff in the facility. E13 stated there's a male Certified Nursing Assistant and there are male staff in therapy. E13 stated that no male was notified to assist R23 with toileting.

R23's investigation report for the fall dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F9999	Continued From page 26	F9999		

7/11/13 documents: Interventions to be implemented to minimize possibility of recurrence of fall-R23 is impulsive, has cognitive deficits, does not use call light, daughter and staff present. Staff eased him to the floor. There were no actual interventions documented.

Fall: 7/26/13 at 9:30am- Location- hallway, Description-nurse noticed resident on the floor. Resident stated, " I just wanted to walk and I stood up." The fall investigation tool documents: Interventions to be implemented to minimize possibility of recurrence- Appears weaker and had a cough. Started on Z-pack, Mucinex, and tessalon pearls. Order for Megace to help stimulate appetite.

Fall: 8/3/11 at 8:42am, Location resident room doorway. Intervention- Place reminder on bathroom door.

Fall: 8/7/13 at 8:45pm, on the floor in his room. Noted 2cm skin tear on his elbow with small bleeding. His wheel chair found on his side.

Fall: 8/11/13 at 7:30pm, in front of room 512. Intervention- this section was left blank as the investigation was not complete as of 8/13/13, there were no documented interventions on R23 ' s care plan.

On 8/13/13 at approximately 1:00pm, E16 (RN, Resident Care Manager) stated that for the fall R23 sustained on 8/3/13 the intervention was to place a sign on his bathroom door. E16 then went to R23 ' s room. Located on R23 ' s bathroom door was a sign which read: " (R23), Please ask for help before you get up from your chair " . However, the bathroom door which was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	9700 GROSS POINT ROAD SKOKIE, IL 60076

(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) COMPLETION DATE
F9999	Continued From page 27	F9999		

a sliding accordion type door was pushed open. The sign was folded up inside the door and not visible. R23 was alone in his room, asleep in bed. R23 ' s bed was on the other side of the bathroom wall and not in view of the door or sign. R23 ' s wheel chair was next to his bed. E16 stated that when R23 fell he was sitting in his wheel chair in front of the bathroom door. The object is for him to read the sign if he is sitting in front of the bathroom door.

For the fall R23 sustained on 8/7/13, E16 stated that R23 fell in the doorway of his room. E16 stated " he has a history of getting up and falling." E16 pointed to a sign posted both on the outside and inside bathroom wall. The sign read " please call, don't fall". When asked how this helps R23 when he's on the other side of the wall. E16 stated, "it's a reminder." E16 also stated that R23 has cognitive impairment and memory problems.

As of 8/13/13, the investigation for the fall R23 sustained on 8/11/13 was not complete. E16 stated she is in the process of completing the investigation. E16 stated that R23 fell outside of his room. E16 stated that R23 wanted to go to his room. E16 stated that staff allowed E16 to go to his room and he was not escorted. E16 added that she had not updated R23's care plan. E16 stated the policy is to update the care plan and add interventions after the investigation is complete. E16 stated that the facility has folded R23's walker up and placed it out of his reach. At this time, R23 remained asleep in his bed with the wheel chair next to the bed. When R23 fell on 8/11/13 he sustained a laceration to the back of his head, and was transferred to the local hospital where he received staples.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145931	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIEBERMAN CENTER FOR HEALTH & REHAB	**9700 GROSS POINT ROAD SKOKIE, IL 60076**

(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) COMPLETION DATE
F9999	Continued From page 28 The facility's policy for fall management documents: Care and Interventions: The care plan will be reviewed and updated to reflect the fall, its causes, interventions, and goals. The policy does not document timeliness of interventions. R23's discharge instructions from the local hospital documents: Head injury, scalp laceration. Make appointment to have staples removed. (B)	F9999		