| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **145931** | A. BUILDING _____ B. WING _____ | **10/02/2020** |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0657<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**<br><br>Based on interview and record review the facility failed to develop a care plan with measurable goals, objectives and individualized interventions to address aggressive ongoing behaviors for one (R1) of five residents reviewed for care planning. Findings include: Per Progress- nurses notes dated: 1-27-2020 at 7:51am reads, R1 attempted to hit a staff member, R1 continue to scream and was punching the staff. On 2-26-2020 at 1:42pm reads, R1 swung his arms and was extremely angry. On 3-7-2020 at 9:50am reads, when staff was trying to assist R1 to a sitting position R1 hit the staff. On 3-31-2020 at 11:38am reads, R1 strike at me (V9- Licensed Practical Nurse). On 4-9-2020 at 5:40pm reads, R1 has shown physical behaviors such as swinging at staff when trying to redirect R1. On 6-4-2020 at 11:36am R1 is refusing care and being combative towards staff when given care. On 6-25-2020 at 3:01pm reads, R1 resistive and combative with care. On 9-20-2020 at 2:45pm R1 touched R2 in the nose and swing his arms and hit V12 (Certified Nursing Assistant on the chest. On 10-2-2020 at 9:05am V18 (MDS/ care plan coordinator) said, after the patient is assessed we develop the care plan, it's important for the front line to see the care plan and know how to care for the patient. The care plan for aggressive behavior related to dementia was developed 9-22-2020, I do not see any other care plans for R1's aggressive behaviors towards staff. R1 should have an aggressive care plan for hitting staff. On 10-2-2020 at 2:30pm V2 (Director of Nursing) said, my expectation of the MDS/care plan coordinator is to develop the care plans based on the patient's health and behavior status, I do not know why R1 did not have any aggressive behavior care plan before 9-22-2020. Facility policy titled, Care Planning, comprehensive resident centered, reads: plans of care are developed by the interdisciplinary team to coordinate and guide care interventions and goals for the resident. |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br><br>Based on interview and record review the facility failed to provide trained staff to monitor residents on a dementia unit. This failure affected two residents reviewed for supervision. Findings include: 10-1-2020 at 1:20pm V5 (Licensed Practical Nurse) said, It was Sunday 9-20-2020 at about 2:45pm several residents were in the common area of wing D, V12 (Certified Nursing Assistant) was monitoring them. V12 called me and told me that R1 touched R2 in the nose and was screaming get up. V12 separated them. I went to check both of the patients and I saw that R2 was sleeping in the sofa and R1 was screaming, saying that no one should be sleeping at this time. 10-1-2020 at 1:40pm V12 (Certified Nursing Assistant) said that on 9-20-2020 at about 2:30pm, I was working on the fifth floor monitoring the patients in the TV area for wing D. I was assigned to 5th floor because I was on light duty, not to push or lift more than 5lbs. R1 moved in his wheelchair very fast and touched R2's nose waking her up. I immediately moved R1 away from the other residents. I was not trained on how to take care of dementia patients. 10-2-2020 at 1:20pm V2 (Director of Nursing) said, V12 (Certified Nursing Assistant) should not have been placed on the 5th floor on the Dementia Unit because V12 does not know how to manage and supervise dementia residents. V12 does not have the four hour dementia training. The fifth floor is a certified dementia unit and the staff members that work in the dementia unit need to have the four hour dementia training on how to care for dementia patients. Facility did not provide a written policy specific to staff training for working on the dementia unit during the course of this survey. |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.