

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/06/2018
NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938		
(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) COMPLETE DATE
S 000	Initial Comments Complaint #1863601/IL103109	S 000			
S9999	Final Observations Statement of Licensure Findings Section 300.610a) Section 300.1210c) Section 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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:	S9999			
			Attachment A Statement of Licensure Violations		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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S9999	Continued From page 1 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. These Regulations were not met as evidenced by: Based on interview, record review, and observation the facility failed to transfer resident with two assist and failed to monitor resident while on the toilet for one resident (R7) of three residents reviewed for falls in the sample of 11. This failure resulted in R7 receiving 11 sutures to R7's left forehead. Findings include: R7's Progress Note dated 5/31/18 at 5:59 PM, documents R7 returned from the hospital with 11 sutures to the facial laceration. The facility's Serious Injury Incident Report dated 5/31/18 documents R7 was on the toilet in the West/North hallway shower room and leaned forward and fell hitting R7's forehead. In this Incident report, V9 Certified Nursing Assistant (CNA) stated V9 was with R7 but could not get to R7 before R7 fell. R7's Restorative Nursing - ADL (Activities of Daily Living) Skills Analysis dated 5/1/18 documents R7 requires extensive assistance of two person for toileting. R7's Minimum Data Set (MDS) dated 5/29/18 documents R7 requires full staff performance by two plus staff for toileting. R7's Care Plan dated 2/6/18 documents R7 requires extensive assistance of one staff and	S9999		

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S9999	Continued From page 2 has not been updated since 2/6/18. R7's Fall Risk Assessment dated 5/16/18 documents R7 is at high risk for falls. R7's Hospital Patient Care Summary dated 5/31/18 documents R7's Discharge Diagnoses as Facial Laceration and Acute Urinary Tract Infection. This Summary also documents to remove sutures in eight days. On 6/4/18 at 4:30 PM, R7 was in R7's room in wheelchair. R7 had several sutures on R7's left forehead. The sutured laceration was approximately two inches long. On 6/5/18 at 9:08 AM, R11 stated R11 was headed to the bathroom when R11 saw V9 (CNA) take R7 to the bathroom in the hall and leave R7 in there. R11's MDS dated 5/17/18 documents R11 is cognitively intact. On 6/5/18 at 10:50 AM, V9 stated R7 was in the dining yelling that R7 needed to go to the bathroom so V9 took R7 to the shower room closest to the dining room. V9 first stated she took washcloths in the bathroom with her but then V9 stated she got washcloths out of a cabinet in the shower room. V9 stated she was with R7 when R7 fell and V9 stated she never left the bathroom/shower room while R7 was on the toilet. On 6/5/18 at 11:27 AM, V10 Registered Nurse (RN) stated V10 was informed by staff that R7 had fallen in the bathroom and she immediately went to assess R7. V10 stated V11 told her V11 was at the sink talking to R7 when R7 leaned over and fell off the toilet. V10 stated she did not see anything, it was just reported to her.	S9999			

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S9999	Continued From page 3 On 6/5/18 at 2:28 PM, V2 (Director or Nursing) stated V9 should have followed whatever R7 was assessed at for transfers. If R7 was assessed as a two person transfer and toileting then there should have been two staff with R7. On 6/5/18 at 3:00 PM, V1 (Administrator) stated there was no reason to doubt V9's statement that V9 did not leave R7 alone in the bathroom. On 6/5/18 at 3:45 PM, V1 stated she watch the camera surveillance of the date and time of the fall and V9 did leave R7 alone in the bathroom. V1 is unsure why V9 left R7 in the bathroom or why V9 lied about being in the bathroom. V1 stated V9 should have never left R7 alone in the bathroom. On 6/6/18 at 1:18 PM, V13, (R7's Physician) stated if R7 was supposed to have more assistance then R7 should have had more assistance to help prevent falls.	S9999			