

DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS

THE DEPARTMENT OF PUBLIC HEALTH	)	Docket No. NH 19-S0060
STATE OF ILLINOIS,	)	
Complainant,	)	
	)	
v.	)	
	)	
GIBSON AREA HOSPITAL & HEALTH SERVICES,	)	
D/B/A, GIBSON COMMUNITY HSP ANNEX	)	
Respondent.	)	

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE; NOTICE OF
PLAN OF CORRECTION REQUIRED; NOTICE OF CONDITIONAL LICENSE; NOTICE OF FINE
ASSESSMENT; NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS;
NOTICE OF OPPORTUNITY FOR HEARING

Pursuant to the authority granted by the Nursing Home Care Act (210 ILCS 45/1-101 et seq.)
(hereinafter, the "Act"), NOTICE IS HEREBY GIVEN:

NOTICE OF TYPE "A" VIOLATION(S) AND ORDER TO ABATE OR ELIMINATE

It is the determination of the Illinois Department of Public Health, State of Illinois, (hereinafter, the "Department") that there has been a failure by Respondent to comply with the Act. This determination is subsequent to a Licensure Investigation conducted by the Department on January 03, 2019, at Gibson Community Hsp Annex, 430 East 19th Street, Gibson City, Illinois 60936. On February 27, 2019, the Department determined that such violations constitute one or more Type "A" violations of the Act and the Skilled and Intermediate Care Code, 77 Ill. Adm. Code 300 (hereinafter, the "Code"). The nature of each such violation and sections of the Code that were violated are further described in The Statement of Licensure Violations which is attached hereto and incorporated herein as Attachment A and made a part hereof.

Pursuant to Section 3-303 of the Act, the above-referenced facility is hereby ordered to abate and/or eliminate the above violation(s) immediately.

A Type "A" violation may affect your eligibility to receive or maintain a two-year license, as prescribed in Sec. 3-110 of the Act.

NOTICE OF PLAN OF CORRECTION REQUIRED

Pursuant to Section 3-303(b) of the Act and Section 300.278 of the Code, the facility shall have 10 days after receipt of notice of violation in which to prepare and submit a plan of correction. Any previous submissions are considered to be comments to the licensure findings and are not eligible as a plan of correction for this notice.

Each plan of correction shall be based on an assessment by the facility of the conditions or occurrences that are the basis of the violation and an evaluation of the practices, policies, and procedures that have caused or contributed to the conditions or occurrences. Evidence of such assessment and evaluation shall be maintained by the facility. Each plan of correction shall include:

- 1) A description of the specific corrective action the facility is taking, or plans to take, to abate, eliminate, or correct the violation cited in the notice.
- 2) A description of the steps that will be taken to avoid future occurrences of the same and similar violations.
- 3) A specific date by which the corrective action will be completed.

If a facility fails to submit a plan of correction within the prescribed time period, The Department will impose an approved plan of correction.

NOTICE OF CONDITIONAL LICENSE

In accordance with Sections 3-305 and 3-311 of the Act, the Department hereby issues a Conditional License for the operation of the Facility. This license replaces the unrestricted license issued to Gibson Community Hsp Annex, 430 East 19th Street, Gibson City, Illinois 60936 on . The Facility's current license number is . The term of the conditional license shall be from . THE CONDITIONAL LICENSE SHALL FOLLOW UNDER A SEPARATE COVER LETTER. THE CONDITIONAL LICENSE SHALL BE CONSPICUOUSLY POSTED IN THE FACILITY BEGINNING ON .

The Conditional License will be withdrawn and an unrestricted license will be issued to Respondent upon the expiration of the term of the Conditional License.

During the term of the Conditional License, Respondent will retain its status as a certified provider of Medicaid services so long as Respondent's facility complies with the applicable federal regulations.

If the Respondent timely requests a hearing to protest the basis for the issuance of the Conditional License, the terms of the Conditional License shall be stayed pending the issuance of the Final Order at the conclusion of the hearing and the facility may operate in the same manner as with an unrestricted license.

NOTICE OF FINE ASSESSMENT

Pursuant to Section 3-305 of the Act the Department hereby assesses against Respondent a monetary penalty of \$25,000.00, as follows:

Type A violation of an occurrence for violating one or more of the following sections of the Code: 300.610a), 300.1210b), 300.1210c), 300.1210d)6) and 300.3240a). The fine was doubled in this instance in accordance with 300.282i) and j) of the Code due to the violation of the sections of the Code with a high risk designation: 300.1210b), 300.1210d)6) and 300.3240a).

Section 3-310 of the Act provides that all penalties shall be paid to the Department within ten (10) days of receipt of notice of assessment by mailing a check (note Docket # on the check) made payable to the Illinois Department of Public Health to the following address:

Illinois Department of Public Health
P.O. Box 4263
Springfield, Illinois 62708

If the penalty is contested under Section 3-309, the penalty shall be paid within ten (10) days of receipt of the final decision, unless the decision is appealed and stayed by court order under Section 3-713 of the Act.

A penalty assessed under this Act shall be collected by the Department. If the person or facility against whom a penalty has been assessed does not comply with a written demand for payment within thirty (30) days, the Director shall issue an order to do any of the following:

- (A) Direct the State Treasurer to deduct the amounts otherwise due from the State for the penalty and remit that amount to the Department;
- (B) Add the amount of the penalty to the facility's licensing fee; if the licensee refuses to make the payment at the time of application for renewal of its license, the license shall not be renewed; or
- (C) Bring an action in circuit court to recover the amount of the penalty.

NOTICE OF PLACEMENT ON QUARTERLY LIST OF VIOLATORS

In accordance with Section 3-304 of the Act, the Department shall place the Facility on the Quarterly List of Violators.

NOTICE OF OPPORTUNITY FOR A HEARING

Pursuant to Sections 3-301, 3-303(e), 3-309, 3-313, 3-315, and 3-703 of the Act, the licensee shall have a right to a hearing to contest this Notice of Type "A" Violation(s) and Order to Abate or Eliminate; Notice of Conditional License; Notice of Fine Assessment; and Notice of Placement on Quarterly List of Violators. In order to obtain a hearing, the licensee must send a written request for hearing no later than ten (10) days after receipt by the licensee of these Notices.

FAILURE TO REQUEST A HEARING WITHIN TEN DAYS OF RECEIPT OF THIS NOTICE WILL CONSTITUTE A WAIVER OF THE RIGHT TO SUCH HEARING.

FINE REDUCTION IF HEARING WAIVED

Pursuant to Sections 3-309 and 3-310 of the Act, a licensee may waive its right to a hearing in exchange for a 35% reduction in the fine. In order to obtain the 35% reduction in the fine, the licensee must send a written waiver of its right to a hearing along with payment totaling 65% of the original fine amount within 10 business days after receipt of the notice of violation.

Plans of Correction, Hearing and Waiver Requests can be emailed to the following email address: DPH.LTCOA.POChearing@illinois.gov. If your facility does not have email capabilities then mail it to the attention of: Sammye Geer, Illinois Department of Public Health, Long Term Care – Quality Assurance, 525 West Jefferson, Springfield, IL 62761.



Sherry Barr
Division Chief of Quality Assurance
Office of Health Care Regulation

Dated this 28th day of February, 2019.

THE DEPARTMENT OF PUBLIC HEALTH
STATE OF ILLINOIS
Complainant,

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GIBSON AREA HOSPITAL & HEALTH SERVICES
D/B/A, GIBSON COMMUNITY HSP ANNEX
Respondent.

AFCI300/19-S0060/Gibson Community Hsp Annex/January 03, 2019/S.Geer

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003552	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 01/03/2019
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NAME OF PROVIDER OR SUPPLIER GIBSON COMMUNITY HSP ANNEX	STREET ADDRESS, CITY, STATE, ZIP CODE 430 EAST 19TH GIBSON CITY, IL 60936
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(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 Incident Report Investigation of 12/18/18 IL108332	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610(a) 300.1210(b) 300.1210(c) 300.1210(d)(6) 300.3240(a) 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 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	S9999		

Attachment A
Statement of Licensure Violations

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

TITLE

(X6) DATE

01/22/19

Illinois Department of Public Health

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S9999	Continued From page 1 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. 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: 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure staff followed facility policies and plan of care for safe transfer for R1 and R2. R1 was transferred without the use of a gait belt resulting in R1 falling receiving craniocerebral injuries. R2 was improperly transferred with a mechanical lift resulting in R2 falling from the mechanical lift receiving orbital and frontal sinus fractures. R1 and R2 are two of three residents reviewed for falls in a sample of three. Findings include:	S9999			

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S9999	Continued From page 2 1. R1's Physician's Order Sheet (POS) dated December 2018 list the following diagnosis: Parkinson's Disease, Dementia without Behavioral Disturbance, Unspecified Atrial Fibrillation and Aftercare following Joint Replacement. The same POS documents R1 receives anti-coagulation therapy with the following medications: Aspirin EC (enteric coated) 81mg (milligrams) tablet by mouth daily and Eliquis 5 mg tablet one tablet twice a day. R1's fall assessment dated 12/3/18 documents R1 was moderate risk for falls. R1's MDS (Minimum Data Set) dated 12/4/18 documents R1 is cognitively intact, requires extensive assist with one staff for transfers and R1's balance is not steady requiring one staff assist to be stabilized. R1's care plan dated 12/13/18 documents R1 ambulates with a walker with extensive assist of one staff. Facility Incident Report dated 12/18/18 documents R1 fell at 10 PM. R1 was being assisted out of the restroom with staff and lost R1's balance. R1 fell backwards and hit R1's head on the door. R1 has a hematoma to the back right side of R1's head that was bleeding. R1 was alert per R1's norm and answers all questions appropriately. ROM (Range of Motion) assessed to upper and lower extremities, within normal limits. R1 denied any hip or leg pain. No internal or external rotation noted to lower extremities. Upper extremities ROM assessed R1 denies any pain or discomfort. Hematoma with abrasion to back right side of head. R1's Nurses Notes dated 12/19/18 at 12:07AM state "(R1) fell at 10 PM. (R1) was being assisted	S9999			

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S9999	Continued From page 3 out of the restroom with staff and lost R1's balance. (R1) fell backwards and hit (R1's) head on the door. (R1) has a hematoma to the back right side of (R1's) head that was bleeding. (R1) alert per norm and answers all questions appropriately. ROM assessed to upper and lower extremities, WNL (within normal limits). (R1) denied any hip or leg pain. No internal or external rotation noted to lower extremities. Upper extremities ROM assessed. (R1) denies any pain or discomfort. (R1) stated tailbone and the back of head hurt. (R1) was assisted up with staff assistance to wheelchair. (R1) again denies any pain or discomfort to upper or lower extremities with transfer. Vital Signs 97.8(Temperature), 67(Pulse), 20(Respiration), 203/82(Blood Pressure), 97% oxygen room air. Area to back of the head cleansed and assessed. (R1) assisted to recliner in room with staff assistance. Neuros(Neurological checks) initiated. (R1) complained of increasing pain to tailbone and head. (R1) states (R1) feels tired and "off". Physician notified of the fall and (R1's) condition. Order received to send (R1) to Emergency Room. R1's Nurses Note on 12/19/18 at 1:31 AM states "Emergency Room called to give report on (R1) and (R1) is being transferred to another hospital." R1's Hospital Emergency Department Discharge Summary dated 12/20/18 documents under "Discharge Diagnosis: Subdural Hematoma secondary to head injury/fall while on Eliquis (blood thinner)." Section titled "Impression" documents "There is interval progression of intracranial hemorrhage (bleeding in near the brain), left-sided subdural hemorrhage, hemorrhagic parenchymal contusion and traumatic subarachnoid hemorrhage is	S9999			

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S9999	Continued From page 4 demonstrated." V4, CNA (Certified Nursing Assistant) stated on 1/2/19 at 2:40 PM, " (R1) and I went to the restroom (R1) pulled her own pants up after she was done. I was standing right next to her. (R1) stood up from the toilet and pulled up (R1's) pants. (R1) and I walked out of the bathroom. shut the bathroom's door we were facing her room we were walking toward the sink for (R1) to wash her hands in the sink which is in the resident's room not the bathroom. I was standing right next to (R1) and (R1) just fell straight back. No, I did not have a gait belt on (R1) or I was not touching her. I was just standing right next to her. I don't work the annex part, I work in OB. I was floated to that area because they needed help. I asked the staff how (R1) transferred and the staff stated (R1) uses her walker. (R1) was not unsteady with gait, (R1) was sitting in her recliner chair and (R1) stood straight up and I handed (R1) her walker. (R1) was not unsteady at all with walking. We went into the bathroom. (R1) was finished and we walked out to the sink and I saw (R1) fall back, I tried to grab (R1) but it happened so fast." V2, Director of Nurses (DON) stated on 1/2/19 at 2:50 PM " (V4) was standing by (R1's) left side from our interview with (V4). There was no gait belt on (R1). (R1) was considered extensive assist. One person assist. Facility policy requires a gait belt to be use on all transfers requiring assistance. (R1) should have had a gait belt on during the transfer. " The facility's undated policy titled "Gait Belt Use" states " A gait belt must be used, if there are no contraindications, every time a resident is transferred or ambulated with assistance. If a	S9999			

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S9999	Continued From page 5 gait belt is used, you must have at least one hand on the gait belt supporting the resident at all times." 2. R2's Face Sheet dated 1/3/19 lists the following diagnosis: Osteoarthritis, Essential Hypertension and Coronary Artery Disease. R2's fall assessments dated 2/16/18 documents R2 to be at high risk for falls. R2's MDS assessment dated 11/9/18 documents R2 to be severely cognitively impaired, and totally dependent on two staff persons for all transfers. R2's care plan dated 11/7/18 documents R2 requires two staff assist with transfers and R2 to be transferred with a mechanical lift. The Facility's form dated 5/8/18 titled "Resident Incident Report" documents R2 had a fall on 5/8/18 at 7:15 PM. Section titled "Narrative of Incident and Description of Injuries " documents "(R2) jerked during transfer per mechanical lift and fell to the floor approximately 4 feet landing on left side, hitting left side of (R2's) head on lower bar of mechanical lift. Noted laceration to the left side of head and blood coming from (R2's) mouth. Applied pressure to open area on head and called ambulance for transfer." R2's Nurses notes dated 5/8/18 at 8:06 PM documents " Nurse was called to room at 7:15 PM per CNA(V5) and upon entering the room I saw (R2) on the floor between the bottom bars of mechanical lift on (R2) left side with blood on left side of head and coming from the mouth. CNA (V5) states she was transferring (R2) to bed per mechanical lift and (R2) jerked causing (R2) to fall to the floor approximately 4 feet landing on left side with left side of head hitting the bar at the base of the mechanical lift."	S9999		

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S9999	Continued From page 6 R2's Hospital Emergency Department Summary Report documents under "History of Present Illness: (R1) fell at nursing home from mechanical lift, approximately 4 feet, complains of facial trauma, epistaxis, left eyebrow laceration and neck pain. Section titled Diagnosis: Orbital Fracture, Comminuted, Eyebrow Laceration, Fracture of Frontal Sinus, Blunt Trauma to Face and Concussion." Facility undated Mechanical Lift Policy documents " All Mechanical Lift transfers should be with two assist." V2, DON stated on 1/2/19 at 2:50 PM " (R2's) injury was due to improper transfer with the mechanical lift. The CNA (V5) was removed from the floor immediately and was terminated the next day. The facility's mechanical lift policy states there must be 2 people to use the mechanical lift." V2 confirmed only V5 was present during R2's mechanical lift. A	S9999		