STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003578	A. BUILDING: _____ B. WING _____	C 09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938

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S 000	Initial Comments Investigation of Facility Reported Incident of 8/17/22/IL150878	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210c) 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 b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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. 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. These requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to follow the established plan of care related to transfers for one (R1) of three residents reviewed for accidents in the sample of three. This failure resulted in an improper transfer, where R1 hit R1's leg on a tilt back wheelchair sustaining a 10-centimeter laceration to the lower left leg requiring 12 sutures. Findings include: R1's Admitting Diagnoses; Non-traumatic Subdural Hemorrhage, Legal Blindness, Lack of Coordination and Muscle Weakness.	S9999		

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S9999	Continued From page 2 R1's Facility Referral/Screen to Rehab services dated 10/21/21 documents R1's transfer status as mechanical lift. R1's Care Plan dated 10/20/21 documents R1's transfer status as requiring a mechanical lift. R1's Minimum Data Set (MDS) dated 7/13/22 documents R1 Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet), total dependance 2-person physical assist. R1 is severely cognitively impaired. R1's Nursing Progress Notes dated 8/17/22 at 6:40pm document V4 (Licensed Practical Nurse/LPN) was called to R1's room. V3 (Certified Nursing Assistant/CNA) and V5 (Agency Certified Nursing Assistant/ Agency CNA) stated that V3 and V5 observed a skin tear on R1's left lower leg. While assessing R1, V3 and V5 stated that V3 and V5 2 person transferred R1 from tilt back chair to R1's bed. V3(CNA) and V5 (Agency CNA) were re-educated on mechanical lift transfers and slings. V4 (LPN) explained that the mechanical lift sling should have been placed under the resident, and then lifted with a mechanical lift. V3 and V5 shook their heads nodding yes they understood. V4 notified Hospice, V6 (R1's Physician), V1 (Administrator) and V7 (R1's Power of Attorney/POA). V6 and Hospice stated to send R1 to the Emergency Room for evaluation and treatment. R1 was sent to Hospital Emergency Room for treatment. V5's (CNA) Facility Investigation Witness Statement dated 8/17/22 at 7:30pm documents upon entering (V5 and V3, CNA) realized the	S9999		

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patient R1 did not have a sling, V5 and V3 attempted to transfer R1 to the bed and upon doing so R1 obtained a skin tear on the lower left leg. V4 (LPN) was notified and followed protocol.

V3's (CNA) Facility Investigation Witness Statement dated 8/18/22 no time documents V5 (Agency CNA) and V3, 2-person assist transferred R1 into bed. At this time there wasn't a mechanical lift sling under R1. V5 was on the inside near the bed, V3 was on the outside. When V3 and V5 got R1 to the bed that's when it was noticed there was blood. That's when V3 noticed the skin tear. V5 stayed with R1, and V3 went and got V4 (LPN). That evening V3 was working on the other side of the hallway, V5 had asked V3 for assist.

R1's Nursing Notes dated 8/18/21 at 2:26 pm document R1 has 12 stitches to the left lower leg, is wrapped in bandage for 24 hours, minimal drainage noted on dressing. R1 was at baseline today.

R1's Hospital Discharge Summary date 8/18/22 document R1 having a 10-centimeter laceration to the left lower leg, received 12 sutures and antibiotic ointment and non-adhesive dressing applied.

On 9/2/22 at 10:28 am, V3 (CNA) said on 8/17/22 at 6:40pm V5 (Agency CNA) asked V3 for assistance transferring R1 from tilt back wheelchair to bed. V3 said, V3 was working the opposite hallway and went to R1's room to assist. V3 said, V5 informed V3 that R1 was a 2-person assist, and V3 didn't observe a sling under R1. V3 said, V3 took the outside arm and V5 took the inside which was closest to the bed and transferred R1 to the bed. V3 said, R1 appeared

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S9999	Continued From page 4	S9999		

to hit R1's lower left leg on the tilt back wheelchair. V3 said, after getting R1 into bed, V3 observed that R1 was bleeding on R1's lower left leg. V3 (CNA) said, V5 stood with R1 and V3 went and got V4 (LPN) who came to R1's room and assessed R1. V3 said, V4 informed V3 and V5 that R1 was a 2 person mechanical lift transfer, and that they should have placed a sling under R1 and used the mechanical lift. V3 said, V3 didn't know R1 was a 2-person mechanical lift resident, and V5 didn't tell V3 that R1 was a mechanical lift transfer. V3 said, R1 was sent to the Emergency Room for evaluation. V3 said, V3(CNA) was educated by V4 on where and how to obtain the transfer status of residents.

On 9/2/22 at 11:50am, V4 (LPN) said, on 8/17/22 at 6:40pm, V3 (CNA) informed V4 that R1 had received a skin tear when R1 was transferred to bed. V4 said, V4 went to R1's room and conducted a head-to-toe assessment of R1 and noted a skin tear to R1's lower left leg. V4 said, V4 contacted Hospice, V6 (R1's Physician) and V7 (R1's Power of Attorney/POA) and informed them of the incident. V4 said, V4 received new orders to send R1 to the Emergency Room for evaluation and treatment. V4 said, the ambulance arrived and transported R1 to the hospital. V4 said, V4 asked V3 (CNA) and V5 (Agency CNA) how R1 was transferred and V3 and V5 informed V4 that they used 2-person stand and pivot. V4 said, V4 informed V3 and V5 that R1 is not a 2-person stand and pivot but is a 2-person mechanical lift. V4 said, V4 educated V3 and V4 on where/and how to obtain the transfer status of residents. V4 said, V4 later learned that R4 received 12 sutures to the left lower leg.

On 9/2/22 at 2:25pm, V2 Director of Nursing (DON) said, on 8/17/22 at 6:40pm V3 and V5

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S9999	Continued From page 5 transferred R1 using a 2-person stand and pivot transfer. V1 said, during the transfer R1 hit R1's left lower leg on the tilt back wheelchair causing a laceration. V1 said, R1 was assessed by V4 (LPN) and was sent to the Emergency Room were R1 received 12 sutures to the left lower leg. V1 said, V3 and V4 should of transferred R1 using 2-person assist, a sling and a mechanical lift, per R1's plan of care. Facility Using the Care Plan (no date); Highlights Policy Statement: The care plan shall be used and developing the resident's daily care routine and will be available to staff personnel who have the responsibility for providing care or services to the resident. Completed care plans are places in the resident's chart and/or in a striped folder located at each nurses' station. Care plans are available on each (Brand) computer and (System Brand/Type) data storage system. CNAs are responsible for responding to the Nurse/DON and change in the residents' condition and care plan goals and objectivities that have not been met or expected outcomes that have not been achieved. Other facility staff noting a change in a resident's condition must also report those changes to the DON. Changes in the resident's condition must be reported to the DON so that a review of the resident's assessment and care plan can be made. Information contained on the care plan and other documents used by the nursing staff shall be maintained in a confidential manner in accordance with established facility policy. (B)	S9999		