STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145979	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON COMMUNITY HSP ANNEX	430 EAST 19TH GIBSON CITY, IL 60936

(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 000	INITIAL COMMENTS Incident Report Investigation to incident of 1/2/17/IL91103	F 000		
F 323 SS=G	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to safely transfer one of three residents (R1) reviewed for falls in a sample of three which resulted in the resident (R1) falling causing a humerus and femur fracture.	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145979	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON COMMUNITY HSP ANNEX	430 EAST 19TH GIBSON CITY, IL 60936

(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 323	Continued From page 1	F 323		

Findings include:

The Incident Report dated 1/6/17 documents on 1/2/17 R1 was being assisted by E3 Certified Nursing Assistant CNA from the commode to her bed. R1 was standing with her walker when she lost her balance and fell. R1 complained of pain to her right arm and right leg. X-rays revealed a fractured right humerus and fractured right femur. R1 was admitted to the hospital and underwent surgery to repair the right femur fracture.

The Minimum Data Set MDS dated 11/14/16 documents R1 required extensive assistance of at least one staff member for transfers and toileting. The MDS documents R1 is not steady and is only able to stabilize self with staff assistance when moving from a seated to standing position or moving on and off the toilet.

The Care Plan dated 11/28/16 documents R1 required one assist with transfers and is at high risk for falls.

On 1/18/17 at 4:05 PM E7 Care Plan and MDS Coordinator stated the documentation in the Care Plan of R1 requiring one assist with transfers, means that R1 requires one staff member to assist her (R1) using a gait belt and keeping their hands on her at all times. E7 stated the MDS documentation of extensive assistance of one staff member means R1 required the staff member to do 50% or more of the work and should be using a gait belt while actively supporting the resident. E7 stated that the CNA (E3) who was helping R1 transfer on 1/2/17 should have been using a gait belt and should have been hands on at all times while the transfer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145979	A. BUILDING _____ B. WING _____	C 01/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIBSON COMMUNITY HSP ANNEX	430 EAST 19TH GIBSON CITY, IL 60936

(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 323	Continued From page 2 was in process. On 1/18/17 at 10:19 AM E3 CNA confirmed she was the CNA that was assisting R1 with transferring back to bed from the commode when she fell on 1/2/17. E3 stated she did not use a gait belt during the transfer and that she was not aware that she needed to use a agit belt with R1 during transfers. E3 stated that she turned to move the commode away from R1's bed and she did not have hands or eyes on R1 at the time of her fall. On 1/18/17 at 11:15 AM Z1 Physician confirmed R1 sustained a right femur fracture and right humerus fracture from the fall that occurred on 1/2/17. The X-ray test dated 1/3/17 documents the indication for the test to be, "pain and deformity after falling". The x-ray results document an, "acute oblique fracture involving the mid shaft of the right femur" and a "fracture through the surgical neck of the right humerus with mild impaction". On 1/19/17 at 9:00 AM E1 Administrator acknowledged that E3 CNA should have put a gait belt on R1 while transferring her and stated E3 was disciplined for not using the gait belt when assisting residents with transfers and mobility.	F 323		