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 _____	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	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 Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.610c)4)B)F) 300.1210a) 300.1210b) 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. c) The written policies shall include, at a minimum the following provisions: 4) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 all of the following: B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling; F) Development of strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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	S9999		

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S9999	Continued From page 2	S9999		

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.

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.

There requirements were not met as evidenced by:

Based on interview and record review the facility staff failed to provide safety for one resident (R21) when using the mechanical lift for transfer for one (R21) of four residents reviewed for accidents in a sample of 23. This failure resulted in R21 falling onto the floor out of of a mechanical lift sling during a transfer requiring a emergency department evaluation and sustaining a facial laceration.

Findings include:

The Physician's Orders dated July 2023 list the following diagnosis for R21: Obstructive Hydrocephalus, Unspecified Dementia with Behavior Disturbance, Bipolar and Seizures.

Facility incident report dated 6/19/2023 documents R21 was being transferred with a

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S9999	Continued From page 3	S9999		

mechanical lift by V7, CNA (Certified Nursing Assistant). R21 was up in the air above the bed in the mechanical sling and the strap broke which caused R21 to fall out of the sling and was assisted to the floor by V7. R21 hit his head, left temple area on the leg of the mechanical lift and received a laceration to left eyebrow and skin tear to left hand along with a large area of bruising the the left hand and arm.

R21's progress notes dated 6/19/23 documents the ambulance was called and transferred R21 to the Emergency Department and R1 returned to the facility at 6:30 AM on 6/20/23.

R21's Emergency Department provider notes dated 6/19/23 documents "presenting to ED for evaluation of fall, head trauma. Staff was assisting patient with a (Mechanical lift transfer) and patient fell off (mechanical lift) and hit his head. Physical exam: Skin- 2 centimeter jagged laceration noted lateral to the left eyebrow, skin tear to dorsum left hand. Laceration repair: Repair method- Tissue adhesive."

V7, CNA stated in interview at 2:48 PM "One of the straps that was on the the mechanical lift hooks broke which caused (R21) to fall out of the sling and V7 assisted (R21) to the floor and (R21) hit his head on the leg of the mechanical lift. V7 stated (R21) was still in the sling above the bed in the air and this is when the sling's strap broke causing (R21) to fall and hit his head."

V2, DON (Director of Nurses) stated in interview on 7/14/23 at 10:05 AM. " The CNA V7 hooked the sling up wrong when transferring (R21). We have two slings one is complete full body sling for transfers and the other sling is one that covers the body under the buttocks area. V2 stated this

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S9999	Continued From page 4 sling you have to criss cross the sling straps in order to use it correctly. V7 did not have the sling applied appropriately and V7 was educated on the proper placement of sling usage, also always have 2 staff when using mechanical lift for transferring residents." The care plan for R 21 dated 5/21/23 states R21 must be transferred with 2 staff and a mechanical lift. The facility policy titled "Safe Lifting and Movement of Residents" revision date October 2009, documents The Policy Statement is "In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents." (B)	S9999		