STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003560	A. BUILDING: _____ B. WING _____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDWATER CARE GIBSON CITY	620 EAST FIRST STREET 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) COMPLETE DATE
S 000	Initial Comments Facitlity Reported Incident of 8/1/23/IL162830	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 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. 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 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	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 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 monitor the positioning of a resident leg during a mechanical lift transfer and during positioning, and complete a thorough investigation for two of three residents (R1, R2) reviewed for accidents on the sample list of four. This failure resulted in R1's left leg bumping into an unknown object when being transferred via mechanical lift into a wheelchair causing a laceration to the lower inner left leg, which required 18 sutures to approximate the laceration. Findings Include: 1) The Facility's Report to IDPH (Illinois Department of Public Health) Office dated 8/4/23 documents on 8/1/23, R1 was transferring via a mechanical lift with assistance of two staff from the bed to the wheelchair when R1's leg was bumped on the wheelchair. First Aide was administered and V4 Physician was notified with orders received to send R1 to the hospital. R1 returned back to the facility the same day with sutures to the left lower extremity. This investigation folder contained witness statements from V5 and V6 CNA's (Certified Nursing	S9999		

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S9999	Continued From page 2 Assistant's) who transferred R1 and V8 RN (Registered Nurse) assigned to R1. R1's Hospital History and Physical dated 8/1/23 by V9 Hospital Physician documents R1 presented to the hospital for evaluation of an injury to the left lower extremity. R1 states that R1 was being transferred with a mechanical lift and somehow got R1's left lower extremity caught. R1 sustained a 7 cm (centimeter) laceration requiring repair with 18 sutures. There is also some bruising to the left lower extremity as well. R1's MDS (Minimum Data Set) dated 8/3/23 documents R1 is alert and oriented and requires extensive assistance of two staff for transfers. On 8/15/23 at 1:00 pm, V5 CNA stated V5 and V7 CNA had transferred R1 into R1's wheelchair around 9:00 am on 8/1/23. V7 CNA left the room and V5 was going to get R1 situated in the chair better when V5 noticed blood coming from under R1's pant leg. V5 stated R1's leg was not bumped as far as V5 was aware explaining R1 "never called out or anything or said it hurt". On 8/15/23 at 1:10 pm, V8 RN stated V8 was alerted by a CNA that R1 was bleeding, that was around 9 am on 8/1/23. V8 explained, "as soon as I (V8) seen it {leg laceration}, I (V8) knew (R1) was going to need sutures." The laceration was on the lower inner leg area. V8 stated V8 applied a dressing over the laceration and sent R1 to the hospital. On 8/15/23 at 2:10 pm, R1 stated R1 sustained a leg laceration a couple of weeks ago but "it is really unclear how I (R1) got the laceration." R1 explained staff were transferring R1 into a wheelchair with the mechanical lift and R1 was	S9999		

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S9999	Continued From page 3	S9999		

already sitting in the chair when all of a sudden, R1 felt a little pinch. R1 explained it was at the same time of the "pinch" that the CNA reported R1 was bleeding. R1 stated R4, roommate at the time, said R4 thought my leg was bumped with the foot rest. R1 stated, "that makes sense because it's a 3 inch V-shape laceration" and the shape of the corner of the foot pedal.

On 8/15/23 at 3:35 pm, V2 DON (Director of Nursing) with V1 Administrator present stated V2 feels like R1 might have bumped R1's leg inside of the wheelchair and with R1 "being so edematous with the lyphedemna", R1's leg "just split when bumped". V2 stated V2 thinks V2 interviewed R4 as a witness to the situation but doesn't have anything in writing and cannot remember what R4 said about the incident.

On 8/16/23 at 9:07 am, V5 again stated, V5 isn't sure how R1 sustained the leg laceration and explained, "all I (V5) know is (R1) made it to the chair safely. Foot pedals were on the chair and I (V5) was holding up (R1's) foot, trying to flip the pedal in place to be able to place (R1's) foot {on the pedal} and that is when I (V5) noticed (R1) bleeding from the other leg." V5 stated, it is very possible that when doing that, the pedal hit R1's leg because it was all at the same time.

On 8/16/23 at 10:16 am, V2 confirmed R1's incident investigation was not thorough as all potential witnesses were not interviewed and that V2 didn't really "dig down for the root cause" explaining, "I (V2) know (R1) hit it {leg} on something.", just don't know what exactly or how.

2.) On 8/15/23 at 11:02 am, V5 and V6 CNA's (Certified Nursing Assistant's) entered R2's room to provide cares. V5 and V6 placed the

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S9999	Continued From page 4 mechanical lift swing under R2 and V6 lifted R2 with the lift into the air and was pushing R2, while suspended in the air and swaying back and forth, toward the wheelchair, which V5 was positioned behind. R2 was facing the wheelchair and slightly bumped R2's left leg on the arm of the wheelchair. At that time, V5 pushed R2's leg, which caused R2 to swing around and was now facing the mechanical lift instead of the wheelchair and guided R2 into a sitting position in the chair. On 8/16/23 at 8:50 am, V2 DON (Director of Nursing) stated residents are being transferred via a mechanical lift, one staff should be operating the machine while the other staff is behind the resident, with hands on them guiding them where they are going. (B)	S9999		