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 _____	R-C 10/06/2023

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 First Certification Revisit to Survey date 8/16/23 Facility Reported Incident of 8/1/23 IL#162830	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210a) 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 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as	S9999	Attachment A Statement of Licensure Violations	

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 _____	R-C 10/06/2023

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
S9999	Continued From page 1	S9999		

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 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

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 _____	R-C 10/06/2023

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
S9999	Continued From page 2 and assistance to prevent accidents. These Requirements were not met evidenced by: Based on observation, interview and record review the facility failed to provide a safe resident transfer with a mechanical lift (R1) and failed to provide safe positioning to prevent an injury for R3. These failures resulted in R1 landing on her bottom on the hard tile floor causing increased pain and R3 being pushed into a dining room table resulting in bruising and skin tear. R1 and R3 are two of three residents reviewed for falls/ accidents on the sample of three. Findings include: 1. The facility Transfers- Manual Gait Belt & Mechanical Lifts policy dated 11/28/12 documents mechanical lift devices will be used for any resident who requires two person assist. The transferring needs of residents will be assessed on an ongoing basis and when using a sit to stand mechanical lift there will be two caregivers assisting. R1's Medical Diagnoses dated 10/6/23 documents R1 is diagnosed with Morbid Obesity, Lymphedema, and Difficulty Walking. R1's Minimum Data Set dated 8/3/23 documents R1 is cognitively intact and requires extensive assist of two staff members for transfers. R1's Incident Note dated 9/2/23 documents R1 was being transferred via sit to stand mechanical lift when slipped down to the floor onto her bottom. R1 complained of pain on her bottom	S9999		

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 _____	R-C 10/06/2023

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
S9999	Continued From page 3 rating it a 10/10. R1's Medication Administration Record dated September 2023 documents R1 had an increase in use of as needed pain medication directly after the failed transfer and for two days after that. R1 requested pain medication on the evening of 9/2/23 after the fall and twice on 9/3/23 and once on 9/4/23. The as needed acetaminophen and ibuprofen were given on top of R1's scheduled Hydrocodone-Acetaminophen 5-325 milligram given twice per day. R1's Nurse Progress Note dated 9/2/23 documents R1 complained of pain on her bottom from hitting the floor. R1's Nurse Progress Note dated 9/3/23 documents R1 was given as needed pain medication for pain on her bottom from the fall. R1's Nurse Progress Note dated 9/4/23 documents R1 complained of pain to her buttocks from hitting the floor. On 10/6/23 at 12:57 PM, R1 stated V10 Certified Nurses Assistant transferred her with the sit to stand mechanical lift. V10 did not lift her to a standing position and was moving very slowly. R1 stated she told V10 to lift the machine higher up so she was standing straight. R1 stated she told V10 her legs were giving out and she couldn't support herself anymore. V10 could not get the lift in position to sit R1 back down in the recliner or on the bed and R1 stated she began to slip down out of the sling. R1 stated she slipped to the ground, landing hard on her bottom. R1 stated her bottom (tailbone) hurt badly for a few days after the fall. R1 confirmed V10 was the only staff member in the room for the transfer.	S9999		

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 _____	R-C 10/06/2023

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
S9999	Continued From page 4 On 10/6/23 at 1:52 PM, V10 CNA confirmed on 9/2/23 she was the only staff member in the room transferring R1 and using the sit to stand mechanical lift when R1 slipped to the floor onto her bottom. V10 stated R1 wanted her to lift her higher and move faster but she was moving as quickly as possible and the machine was positioned properly. V10 confirmed R1 slipped out of the mechanical lift and landed on the floor on her bottom. On 10/6/23 at 2:20 PM, V9 Registered Nurse stated she was the nurse assigned to R1 when R1 slipped down out of the sit to stand mechanical lift to the ground. V9 stated V10 CNA was the only CNA in the room transferring R1 at the time and when V9 went into the room to assess R1 after the fall, R1 stated she did not feel V10 had been transferring her the right way. R1 appeared anxious and stated her bottom hurt from the hard ground. V9 stated if there were two CNAs in the room at the time of the transfer it might've helped prevent the incident. On 10/6/23 at 3:00 PM, V2 Director of Nurses stated staff should follow the facility's mechanical lift policy. V2 DON confirmed the facility policy states two staff members are required for sit to stand mechanical lift transfers. V2 confirmed due to R1's size and physical disabilities due to obesity and weakness it would have been beneficial to have two staff members assisting with R1's transfer and could have potentially prevented R1 from slipping down to the ground. V2 was unaware of R1's buttocks (tailbone) pain following the fall. 2. R3's Diagnoses Sheet updated 7/18/23 documents the following diagnosis: Alzheimer's	S9999		

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 _____	R-C 10/06/2023

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
S9999	Continued From page 5 Disease. R3's Physician Order Sheet dated 10/6/23 documents R3 has a skin tear to R3's left lower extremity and is monitored for R3's bilateral lower leg bruising. R3's Minimum Data Set (MDS) dated 7/6/23 documents the following: R3's Brief Interview of Mental Status score of 00 (zero/zero) out of a possible 15, which indicates R3 has severe cognitive impairment. The same MDS documents R3 requires one person, extensive physical staff assistance moving to and from a lying position, does not ambulate and requires extensive staff assistance of one person for mobility on and off unit. R3's Care Plan dated with a revised interventions on 7/14/23 documents the following: "Restorative eating; Be sure I am positioned close to the table sitting upright. Apply brakes on the wheelchair." The same Care Plan revised intervention 7/14/23 documents "I am at risk of skin breakdown." Interventions include: "Check my environment for sharp edges to avoid injury." R3's "Health Status Note" dated 9/28/2023 at 11:08 am signed by V8, Licensed Practical Nurse (LPN) documents the following: "CNA (Certified Nursing Assistant, unidentified) alerted Nurse (V8, LPN) to (a) skin tear on res (resident, R3) left shin. upon evaluation skin tear is (measured length) 1.5 in (inch) by .5 in (measured width). Res (R3) has bruising on both shins. Res shins are noted at the same level as tables in the dining room before res chair (geriatric, recliner-type wheeled chair) is lowered to a sitting position from laying. Staff educated on lowering legs before pushing (geriatric chair) up to table. Dr	S9999		

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 _____	R-C 10/06/2023

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
S9999	Continued From page 6 /POA (unidentified, Doctor and Power of Attorney) notified. Will continue care." R3's "Wound Assessment Detail" Report" dated 9/29/23 that documents R3's Left lower extremity skin tear with 'partial flap loss' injury was facility-acquired. On 10/6/23 at 10:45 am, V6 Certified Nursing Assistant (CNA) and V7, CNA) transferred R3 via a full mechanical lift from R3's bed to R3's geriatric wheeled chair. R3 had bilateral lower extremity fading bruising that measured approximately half the size of a dollar bill. below the left shin bruising was a four inch by four inch bordered gauze dressing on R3's left mid-shin. On 10/6/23 at 2:20 pm, V8, LPN stated V8 did the initial evaluation of R3's bilateral lower legs and found shin bruising and skin tear after she was notified by a CNA (unidentified). V8 deemed it was likely that R3's knees /shins hit the dining room table as R3 was positioned in R3's reclined geriatric chair. R3's knees/shins were directly in line with the table edge. On 10/6/23 at 2:48 V2, Director of Nursing/ Wound Nurse stated R3's 9/28/23 skin tear injury and bruising on R3's lower legs were caused when a CNA (unidentified) failed to put the foot of R3's reclined geriatric chair down, before pushing the chair up to the dining table. V2 confirmed R3's skin tear and bruising could have been prevented. "All CNA's have been educated on positioning all residents with geriatric chairs to prevent further injuries." (B)	S9999		