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 _____	03/25/2021

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GILMAN HEALTHCARE CENTER	1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938

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S 000	Initial Comments Annual Licensure and Recertification	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) 300.610a) Resident Care Policies 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. 300.1210b) General Requirements for Nursing and Personal Care 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.	S9999	Attachment A Statement of Licensure Violations	

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300.1210d)6) General Requirements for Nursing and Personal Care

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 regulations are not met as evidenced by:

Based on record review, observation and interview the facility failed to secure R32 while R32 was left in bed unattended by direct care nursing staff. This failure resulted in an unwitnessed fall to the floor from an elevated bed, which caused a laceration to R32's left posterior scalp that required emergency medical treatment of nine staples. R32 is one of four residents reviewed for falls on the sample list of 20.

Findings include:

On 3/23/21 at 10:50 am, R32 was positioned in a right side lying, fetal position. R32 was laying on a low-flow air mattress. The mattress was on a bed frame, lowered to 18 inches off the floor. R32 had a speciality call light placed on R32's pillow, five (5) inches from R32's right cheek. R32 had nine staples on the left posterior aspect of his head, two inches behind R32's left ear. R32 stated R32 fell from R32's bed causing the injury to R32's head. R32's speech was garbled as R32 continued to speak unintelligibly. No other details of the fall could be understood from R32.

On 3/23/21 at 12:30 pm V2, Director of Nursing

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(DON) stated "(R32) had a reportable (notification requirement to State Agency of a fall with injury) fall on 3/18/21 and an investigation is in progress." V2 also stated "We (the facility) added a new fall intervention immediately to maintain (R32's) bed in the lowest position."

R32's Minimum Data Set (MDS) dated 2/16/21 documents R32 has a Brief Interview Of Mental Status score of 2 out of 15 (severe cognitive impairment). The same MDS documents R32 is totally dependent on physical staff assistance with bed mobility, transfers, personal hygiene, locomotion on and off unit via wheel chair and does not ambulate. The same MDS documents R32's primary diagnoses includes the following: Other Neurological Condition, Osteoporosis, Chronic Pain and Anxiety. The same MDS documents R32 has one, unhealed Stage IV Pressure Ulcer and has a pressure reducing device on R32's bed and chair.

R32's Nurse Progress Note dated 3/18/21 at 4:51 pm, signed by V11 Registered Nurse (RN) documents the following: "RN (V11,) called by the CNA (Certified Nursing Assistant, V12) stating that resident (R32) is on the floor, upon getting to the resident's room, resident noted on the floor, lying on his left side, and facing his (R32's) bed, and moderate amount of bloody drainage noted under resident's head. Resident is not able to give a full description of what he was doing prior to the incident, spinal alignment maintained and resident turned to his right side, resident noted to have a 7 cm (seven centimeter) moderately deep laceration to his (R32's) left occipital, resident denied pain to the site, site cleansed with soap and water and pressure dressing applied to site, and bleeding controlled. pupils PERRLA (Pupils Equal, Round, Reactive to Light and

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Accommodation), resident did not lose consciousness, resident denied headache and/or dizziness, MD (Physician, unidentified) called with assessment findings and notified of incident, and resident transferred to the ED (Emergency Department) at (regional hospital) for eval (evaluation) and treatment, resident's POA (Power of Attorney, unidentified)called and notified of incident per protocol (fall) , DON (V2, Director of Nursing) and administrator (V1, Administrator) notified of incident (R32's Fall) per facility protocol, EMTs (Emergency Medical Technician's) called and resident transferred to the ED. will follow-up."

R32's "Safety Events-Fall Incident-Accident Event/ Report" dated 3/18/21 document the following diagnoses: Other Seizures (Primary, Admission), Generalized Anxiety Disorder, Congenital Malformation Syndromes, Predominantly Affecting Facial Appearance, Unspecified Intellectual Disabilities, Other Chronic Pain, Age-related Osteoporosis with current Pathological Fracture (history on admission 8/18/20), Unspecified Site, Initial Encounter for Fracture, Laceration without Foreign Body of Scalp, Initial Encounter, and Unspecified Open Wound, Unspecified Knee, Initial Encounter.
The same "Safety Events-Fall Incident-Accident Event/ Report documents R32 had an unwitnessed fall at 4:45 pm. The same report documents "Description of the fall incident: Resident found lying on the floor in his room facing his bed, and on his left side."

R32's "(local acute care) Medical Center, After Visit Summary Report" dated 3/18/21 documents the following: "Reason for (the) Visit, Head Laceration. Diagnoses * Injury of Head, initial

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encounter, (and) * Laceration of scalp, initial encounter. Imaging Tests, CT (computed axial tomography) brain including bone windows for trauma, (and) CT cervical spine without contrast. Done Today, Laceration Repair."

R32's Care Plan dated 3/2/21 documents the following fall intervention updated on 3/18/21 (the same date of R32's unwitnessed fall with injury): "Category: Falls, (R32) is at risk for falls and injuries related to ID (Intellectual Disability), impaired mobility, incontinence, seizure d/o (disorder) and
medication use. He has a history of falls.
Long Term Goal Target Date: 02/18/2021 (typo, 5/18/21 per updated categories on the same care plan)
Falls and significant injuries will be minimized through (by) interventions through next review date.
Approach Start Date: 03/18/2021 (same day as R32's fall with injury)
Keep bed in lowest position.
Nursing (discipline responsibility)."

On 3/24/21 at 2:20 pm, V3, RN / Assistant Director of Nursing (ADON) / Wound Nurse, and V9, CNA entered R32's room to provide R32's incontinence care and wound care. V9, CNA raised R32's bed level up to three feet off the floor to perform incontinence care. R32 laid on a low-flow air mattress. V3 and V9 provided total assistance to repositioning R32 in bed. R32 was repositioned from a right side lying position to R32's back, then to a back lying position onto R32's left side position. R32 did not assist with repositioning. After V9 provided incontinence care and V3 provided pressure ulcer treatment, V3 cleansed R32's left posterior occipital region wound. R32 had nine staples present that closed

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S9999	Continued From page 5 the left posterior scalp wound. While V3 cleansed the wound, R32 stated he had a fall from bed. R32's also stated "My bed was way off the floor." V3 stated R32's scalp staples were due to R32's fall on 3/18/21. V3, RN/ADON/Wound Nurse, V9, CNA and R32 confirmed R32 can not move himself in bed. V3 also stated "(R32) has the low air- flow mattress that shifts according to (R32's) weight, because (R32) has history of pressure ulcers and can't position himself in bed." On 3/24/21 at 2:45 V12, CNA stated the following: " I (V12) was providing (R32's) care when (R32) fell and hit his (R32) head 3/18/21." V12, CNA also stated "I was getting (R32) up for supper. I got him (R32) all cleaned up and dressed and (then) left him for a few seconds to get the (mechanical lift) sling. The (mechanical lift) sling was in the hall, on the railing. I got the sling and told (V10, CNA) that I (V12, CNA) needed help transferring (R32). In those few seconds, (R32) had fallen to the floor from (R32's) bed. The bed was up off the floor about two and a half or three feet. The bed was up because I had been providing his incontinence care and getting him dressed and so I could transfer (R32) by (mechanical lift). I (V12) should have put the bed down all the way in the lowest position before I (V12) left (R32's) room. (R32) can't really move on his own. I (V12) may have had him (R32) off center in his bed. I don't know how his weight shifted. I (V12) feel really bad that he (R32) fell." On 3/25/21 9:00 am, V2, Director of Nursing stated the following: "I completed the fall investigation for (R32's) fall 3/18/21. The root cause of (R32's) fall was that (R32) was too close to the edge of the bed when the CNA (V12) left the room, leaving (R32) unattended with (R32's) bed still in the elevated position after (R32's)	S9999		

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S9999	Continued From page 6 cares had been provided. (R32) has a birth anomaly with a larger than normal head. (R32) does move his head back and forth and must have shifted his weight enough, resulting in (R32's) fall with injury." (B)	S9999		