STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145347	A. BUILDING _____ B. WING _____	C 05/17/2012

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

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F 323	Continued From page 5 and that, "in retrospect," the mechanical lift would have been the safest choice for R1's transfers.	F 323		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATION: 300.610a) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care 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	F9999		

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F9999	Continued From page 6 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following: Based on observation, record review and interview, the facility failed to provide safe transfer technique or utilize a gait belt or assistive device for a non-weightbearing resident (R1) of four residents sampled for falls/abrasions to prevent injury. These failures resulted in a laceration of the inner ankle that required hospital treatment and sutures. Findings include: According to admission records and the current Physician's Order Sheet for 5/12, R1 has diagnoses including Congestive Heart Failure, Cerebrovascular Accident, Alzheimer's, Neurodermatitis, Chronic Obstructive Pulmonary Disease, Dehydration and Anorexia. The Minimum Data Set (MDS) for 2/20/12 assesses R1 with severe cognitive impairment, R1 does not ambulate, and requires total assistance for all activities of daily living (ADLs), including two-person physical assist for transfers. According to the Hospice Plan of Care and confirmed by Z1 (Hospice nurse) on 5/17/12 at 9:00am, R1 has received Hospice services since 8/10 for Dementia, and was again recertified for Hospice on 5/16/12. .	F9999		

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F9999	Continued From page 7	F9999		

The incident report dated 4/3/12 states that three skin tears were discovered on R1's left arm. The Manager's Investigation signed by E6 (Director of Nursing) states that, according to Z1 (Hospice nurse), R1 "wiggles in chair and scratches through sleeve protectors" to scratch skin.

The incident report dated 4/20/12 stated that E3 (Certified Nurse Aide/CNA) and Z2 (Hospice CNA), "transferred res. (resident) and repositioned res. from bed to {highback specialized} wheelchair. {Z2} noticed blood on L' (left) heel. Laceration to L' heel. Sent to ER (emergency room) for evaluation." The Manager's Investigation signed by E6 states "{E3 and Z2} educated on transferring {with} care. Both CNAs verbalized understanding. . ." E3's written statement dated 4/20/12 states that Z2 asked E3 to help transfer R1 from the bed to the wheelchair. "With the 2 of us we transferred her. We straightened her up. . . . {R1} was bleeding from her left heel." Z2's written statement states that "when transferring {R1} from her bed to chair with {E3}, her leg must have been bumped, patient didn't say 'ow'. I noticed blood dripping, covered wound and grabbed staff nurse." The Nurses Note for 11 - 7 on 4/20/12 states "Resident sent to {hospital} for large laceration on L' heel at 6:40am. . . ."

The hospital Emergency Department Nursing Record dated 4/20/12 notes "pt (patient) has approximate 7cm (centimeter) by 3cm gapping wound to medial left ankle. . . ." R1 was treated with sutures and steri-strips. The Physician notes on this report also describes the "7 - 8cm very irregular shaped laceration with torn very

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F9999	Continued From page 8	F9999		

macerated tissue. . . ." This report also demonstrates by diagram an area of "tissue loss."

On 5/10/12 at 10:20am, Z1 had just finished changing R1's dressing to the laceration. Z1 stated that the area was now "healing well" and R1 had been on antibiotics as a precaution. Z1 stated that R1 had been a 2 person transfer "because she was less than 150 pounds" and now was a mechanical lift. Z1 stated that in investigating the incident, they determined that R1 hit her inner ankle on the exposed screw/bolt on the left outer side of the folding footrest on the specialty wheelchair. Upon examination, the screw/bolt was not sharp, but did have hard, defined edges. Z1 stated that R1's skin was "very thin and very fragile." On 5/19/12 at 9:15am, the lacerated area was observed with Z1. While the laceration was healing well, the surrounding skin on the ankle and lower leg was noted to be thin, dry, and friable in appearance. Another small skin tear was noted above the laceration on the lower leg approximated with steri-strips.

E3 confirmed her written statement on 5/10/12 at 11:45am. E3 stated that, on the morning of 4/20/12, Z2 asked E3 to help with the transfer, and that R1 was already dressed and set up at the edge of the bed. E3 demonstrated how she and Z2 transferred R1, lifting her "under the arms" while transferring from the bed to the chair. E3 stated they then lifted R1 again to "straighten her out" to get her farther back into the seat of the chair, and that is when E3 thinks R1's ankle "caught" on the bolt on the outer part of the footrest. E3 reports that R1 did not react, but Z2 did see the blood, and called the nurse. E3

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F9999	Continued From page 9	F9999		

stated she "thought this would be a smooth transfer, but it did not turn out that way." E3 stated that R1 does not bear weight, and E3 "did not remember" if they used a gait belt for the transfer.

On 5/10/12 at 12:25pm, Z2 also confirmed her written statement. Z2 stated they do not use a gait belt and that they have "transferred {R1} that way forever." Z2 stated she always gets help to transfer R1, as she did that morning with E3. Z2 stated they lifted R1 under her arms to the chair, and then lifted R1 up again to sit her back in the chair. Z2 stated that is when R1 hit her ankle on the side of the footrest that was "sticking out." Z2 stated that the footrest was folded up, but R1's ankle hit that outer connection. Z2 stated she covered the laceration immediately and got the nurse. Z2 stated that R1 does not bear weight, and that R1 "likes to keep her legs tight together."

The careplan approach under the problem of Totally Dependent for all ADLs dated 7/13/11, last reviewed on 3/6/12, was "Transfer PRN (as needed) using pivot transfer." A handwritten undated addition had changed this to mechanical lift. The facility's Gait Belt Policy states "Mandatory gait belt usage for all resident handling with the exception of bed mobility and medical contraindications. This policy is to be followed at all times. Failure to adhere to this policy will result in disciplinary action. . . ."

On 5/10/12, E2 (Assistant Director of Nursing) was asked if there was any transfer assessment as to the most appropriate type of transfer for R1, given R1's non-weightbearing status. E2 returned at 2:00pm with CNA ADLs

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F9999	Continued From page 10 Documentation sheets for 2/12 and 5/12 that indicate staff provide total assistance with 2 staff for transfers. At 2:30pm, E2 and E1 (Administrator) stated they did not have a transfer assessment by Physical or Occupational Therapy, and also discussed if a stand-pivot transfer was appropriate for R1, even if a gait belt had been used, as staff did not have control of R1's legs/lower body. On 5/17/12, Functional Assessment sheets were provided, that were not in the current medical record. Starting with 11/8/11, R1's transfers were scored as extensive assist with 1 staff person for stand-pivot transfer. However, weight bearing status was described as "NWB" (non-weightbearing). Also indicated as NWB with one assist were the Functional Assessments for 1/31/11, 7/4/11, and 9/26/11. When asked if there were any more current assessments, the facility provided two more. The first one dated 2/20/12, indicates "PWB" (partial weight bearing) and requiring 2 assist for transfers; however, no other functions on this assessments had changed or improved. The assessment dated 5/7/12 again indicated NWB, requiring 2 assist for transfer, did not indicate a transfer technique, and no other functions had changed. On 5/17/12 at 8:45am, E6 stated she was not aware that the CNAs were not using a gait belt, and that, "in retrospect," the mechanical lift would have been the safest choice for R1's transfers. B	F9999		