Illinois Department of Public Health FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C IL6000681 B. WING 04/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7588 STAUNTON ROAD** HERITAGE HEALTH-GILLESPIE GILLESPIE, IL 62033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S 000 **Initial Comments** S 000 Investigation of Facility Report Incident of 3/8/22/IL145340 Final Observations S9999 S9999 Facility Report Incident Investigation to incident of 3/8/22/IL145340 Statement of Licensure Violations: 300.610a) 300.12106) 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 b)The facility shall provide the necessary care and services to attain or maintain the highest Attachment A Statement of Licensure Violations practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

llinois Department of Public Health

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 05/20/2022 FORM APPROVED

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C IL6000681 B. WING 04/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7588 STAUNTON ROAD HERITAGE HEALTH-GILLESPIE GILLESPIE, IL 62033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) S9999 Continued From page 1 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. 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 nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These regualtions were not as evidenced by: Based on observation, interview, and record review, the facility failed to provide safe transfers for 1 of 6 residents (R31) reviewed for accidents in the sample of 32. This failure resulted in R31 sustaining a laceration to the Right posterior calf requiring being sent to the emergency room and receiving 7 sutures. Findings include: 1. On 04/05/22 at 1:00 PM , V2, Regional Nurse, stated that V2 had received a call from previous Director Of Nursing (DON) reporting that when staff were transferring R31 to bed with partial mechanical lift and R31's legs became weak while still in the partial mechanical lift and moved over bed causing laceration to R31's right calf. V2 stated after the occurrence, maintenance looked

at R31's bed and padded the bed frame, therapy

PRINTED: 05/20/2022 FORM APPROVED

Illinois	Department of Public	Health	FORM APPROVE				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DA	(X3) DATE SURVEY COMPLETED C 04/07/2022	
		, and the state of	A. BUILDING:		CO		
		IL6000681					
NAME OF PROVIDER OR SUPPLIER STREET ADI			DRESS, CITY	, STATE, ZIP CODE		10112022	
HERITA	AGE HEALTH-GILLESP	IE 7588 STA	UNTON RO	OAD .			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	D.PE CONTRACTOR	
S9999	9 Continued From page 2		S9999				
	and R31 changed to V2 stated that the nimmediately if Certinas to increase assistated that V2 would transfer assistance On 4/5/2022 at 2:05 Nurse (LPN), stated transferring R31 to I mechanical lift and It V8 stated there was sharp corners. V8 stated there was sharp corners. V8 stated to apply pressur calf to stop the bleed sent to the emergen sutures. V8 stated the event weakness in the event weakness in the event was stated that the event weakness in the event was stated that the state of the event weakness in the event was stated that the state of the event was stated that the event was stated the event wa	PM, V8, Licensed Practical that 2 CNAs were ped with the use of partial pumped R31's leg on the bed, an area on the frame with sated that R31 was already in sed R31. V8 stated that V8 to the laceration on R31's ling. V8 stated that R31 was cy room and returned with 7 lat R31 has increased ning.	1				
	that V9 was transfer partial mechanical lift to the sling being over leg on the bed. V9 st requires more assistant mechanical lift On 4/5/2022 at 2:12F V10 was in R31's roof fall during transfer. On 4/5/2022 at 2:18 F Director, stated that V bed frame. V7 stated	M, V10 ,CNA, stated that m to make sure R31 didn't					
	R31's Minimum Data	Set (MDS), dated				1	

Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C IL6000681 B. WING 04/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **7588 STAUNTON ROAD** HERITAGE HEALTH-GILLESPIE GILLESPIE, IL 62033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) S9999 Continued From page 3 S9999 2/10/2022, documents that R31 is severely cognitively impaired, requires extensive assistance and one person physical assistance for bed mobility, and transfers. R31's Interdisciplinary Resident Screen, dated 3/9/2022, documents R31 was changed to full mechanical lift on 3/8/2022, therapy deems as safest transfer to remain a full mechanical lift. R31's most current electronic face sheet documents a diagnoses to include contractures of right and left hand, and primary generalized osteoarthritis. R31's Progress Notes, dated 3/8/2022 at 9:00 PM, document while staff were transferring R31 to bed they accidentally bumped R31's right calf on the metal bedframe causing a laceration. R31's notes document the laceration as approximately 4 Centimeter (CM) deep and R31 was sent to the Emergency room. R31's Progress Notes, dated 3/8/2022 at 10:41 PM. document that R31 returned to the facility with 7 sutures to R31's right calf, an order for antibiotics for wound healing, and a tetanus was given in the emergency room. R31's Progress Notes, dated 3/22/2022, document sutures were removed and steri strips in place. On 4/5/2022 at 3:15PM, V2 stated that during transfers if resident has a changed, staff can be provided more assistance and that is what she would expect. On 4/6/2022 at 2:00PM, V14, Medical Director, stated if a resident receives a laceration during a transfer, of course, the transfer was an unsafe transfer.

PRINTED: 05/20/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED IL6000681 B. WING 04/07/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7588 STAUNTON ROAD HERITAGE HEALTH-GILLESPIE GILLESPIE, IL 62033 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) S9999 Continued From page 4 S9999 The Facility Safe Resident Handling Program Transfer and Bed Mobility Assessment Tool, revised 2/14/2018, documents caregivers should always do the safest transfer possible for both the resident and employee. It documents that Caregivers can always increase the level of assistance BUT can never decrease level of assistance. The tool documents if the level of assistance is increased, immediately notify the floor nurse so that the resident can be evaluated. (B) Illinois Department of Public Health

STATE FORM

Illinois Department of Public Health