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	01/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilman Healthcare Center	1390 South Crescent Street, Box 307 Gilman, IL 60938

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40385 Based on observation, interview, and record review the facility failed to ensure all mechanical lift slings were routinely assessed and replaced in accordance with manufacturer's instructions and facility policy. This failure resulted in a mechanical lift sling breaking during R1's transfer which caused R1 to fall from the mechanical lift and sustain head lacerations that required staple closure. This failure has the potential to affect seven additional residents (R2, R3, R4, R5, R6, R7, R8) of eight residents reviewed for mechanical lift transfers in the sample list of eight. Findings include: The facility's Safe Resident Handling/Transfers policy dated December 2023 documents residents require safe handling during transfers to prevent/minimize risk for injury and staff will inspect equipment prior to use. This policy documents if equipment is damaged, broken, or not functioning properly the equipment will be removed from further use. This policy documents manufacturer's instructions on proper sling sizing and tracking of service times will be followed, slings will be assessed/inspected for damage, and damaged, broken, or unsafe slings will be removed from service and replaced. The Full Body Sling manufacturer's instructions for use dated 2023, provided by V1 Administrator, documents Always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use. Recommended to replace slings at minimum every six months. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's Care Plan revised 1/23/24 documents R1 is at risk for falls and injury, R1 slipped out of mechanical lift sling on 12/29/23, R1 had a laceration, and R1 returned to the facility with staples to be removed in 10-14 days. R1's Provider's Progress Note dated 1/3/24 at 9:01 AM, recorded by V9 Nurse Practitioner, documents Patient is a poor historian due to cognitive/psychiatric impairment Chief Complaint/Reason for this Visit S/p (status post) fall with laceration to head. (R1) seen for follow up S/p fall with laceration to head. Per staff, on 12/29/2023, CNA (Certified Nursing Assistant) and Nurse was transferring resident to bed when he slid out of the (full mechanical lift) sling. Resident was lowered to the bed when he slipped out of the bottom of the (full mechanical lift) sling on to his bed and hit his head during transfer. He was then transferred to ED (emergency department) for eval (evaluation), CT (computed tomography) scan showed no fracture or intercranial bleed. Lacerations to scalp were closed with staples. 3 staples to the left side of his head and 2 on top of his head. Staples to be removed in 10-14 days. The facility's Final Investigation Report dated 1/5/24 documents on 12/29/23 R1 had lacerations to the left side and front/top middle of head and based on the investigation R1's left lower leg slid out of the full mechanical lift sling during R1's transfer which caused R1 to shift forward and hit R1's head on the mechanical lift. This report documents R1 was transferred to the emergency room and returned to the facility with staples to the lacerations. V3 Licensed Practical Nurse (LPN) written statement dated 12/29/23 documents a CNA asked V3 to assist in transferring R1 to bed and the CNA had R1 already prepared for the transfer. This statement documents R1 was positioned over top of the bed, R1 slid out of the bottom part of the sling, R1 was bleeding from R1's head and appeared to have hit R1's head while sliding out of the sling. This statement documents R1 was startled and crying, the sling appeared to have ripped during transfer, the sling was destroyed to ensure discontinued use and all staff were in-serviced on the full mechanical lift slings. V4 CNA's written statement dated 12/29/23 documents V4 asked the nurse (V3) to assist with R1's chair to bed mechanical lift transfer, V4 was the one who prepared R1 for the transfer, and R1 slipped out of the bottom of the sling while R1 was positioned over top of the bed. This statement documents R1's head was bleeding and V4 thought R1's head hit the bar on the full mechanical lift. R1's emergency room Summary dated 12/29/23 documents R1 was evaluated for a scalp laceration and these lacerations were closed with staples. The Inservice Sign in Sheet dated 9/21/23 documents V6 Restorative CNA instructed nursing staff to check mechanical lift slings prior to use. The (Full Mechanical Lift) Sling Monitor logs dated 12/8/23-12/31/23 document mechanical lift sling inspections with 27 entries of slings that are not coded with a number. These logs document to identify the sling model inspected, asks if the sling was functioning properly, and if not functioning properly describe the steps taken. The 12/29/23 QAPI (Quality Assurance Performance Improvement) Review on the Use of the Slings for the Mechanical Lift Machine lists slings numbered 1-50 and asks if any tears, rips, or holes were observed on the sling fabric, if the stitching on the sling fabric was observed for signs of fraying, if the sling loops had any fraying or signs of damage, and if the safe working load label was visible. This log documents actions that were taken to address concerns found from the audit and eight slings were discarded. There is no documentation prior to 12/29/23 that all slings were labeled to ensure all slings were routinely inspected and tracked. There is no documentation to show when these slings were purchased and how often they are replaced. The Midnight Census Report dated 1/22/24 documents eight residents (R1-R8) use full mechanical lifts for transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/24 at 8:40 AM V5 and V10 CNAs transferred R2 from the chair to the bed with a full mechanical lift. At 8:49 AM V13 and V14 CNAs transferred R1 from the chair into the bed with a full mechanical lift. At 9:07 AM V5 and V11 CNAs transferred R3 from the chair to the bed with a full mechanical lift. On 1/23/24 at 8:08 AM V3 LPN stated V3 assisted V4 with R1's mechanical lift transfer on 12/29/23, V3 heard a pop sound, and R1 slid out of the full mechanical lift sling onto the bed. V3 stated R1's forehead was bleeding and V3 assumes R1 hit R1's head on the bar of the full mechanical lift. V3 stated the bottom left looped strap of the sling, that attaches to the lift, broke causing the popping sound. V3 stated laundry staff are responsible for inspecting the slings and the CNAs should inspect the sling before use. V3 confirmed V3 did not inspect the sling as V4 already had R1 setup for the transfer. On 1/23/24 at 10:14 AM V4 CNA stated V4 had R1 set up for the mechanical lift transfer, V4 did not check the sling prior to use/transfer and V4 should have. V3 assisted V4 with R1's transfer, the sling leg strap snapped, and V4 assumes R1 hit R1's head when R1 fell from the lift onto the bed. V4 stated the next day the facility purchased new mechanical lifts and slings, which could have prevented this incident since there were prior concerns with the facility's full mechanical lift slings being unsafe. On 1/23/24 at 9:22 AM V6 Restorative CNA stated V6 is responsible for checking mechanical lift slings weekly for signs of wear and tear such as rips and fraying, and if signs of wear/tear are noted then the sling is taken out of use. V6 stated laundry staff also inspects the lifts and they are the ones who keep a log of this. V6 stated when new slings are purchased, they are numbered for tracking and when we are low on supply of slings more are purchased. V6 confirmed there is no specific frequency for how often the slings should be replaced. V6 stated V6 was unsure what number sling was used for R1's transfer and V6 was told that the sling strap broke and it was discarded due to being faulty. At 9:46 AM V6 stated V6 has a master list of all of the facility's slings and this list was completed two weeks ago. At 11:53 AM V6 confirmed V6 did not have a master list for all slings and there was no tracking system in place for slings prior to 12/29/23. V6 stated it was difficult to track and ensure all slings were routinely inspected since V6 did not have a master list prior to 12/29/23. On 1/23/24 at 9:35 AM V12 Laundry Aide stated laundry staff document sling inspections and these forms recently changed. V12 stated the slings are numbered and are inspected for signs of wear/tear, rips and fraying each time they come through the laundry. V12 stated if there are concerns with the slings they are taken out of use and turned into V6 or V8 Housekeeping/Laundry Supervisor. On 1/23/24 at 9:39 AM V8 stated we recently switched to a different form to document sling inspections that is easier to understand and asks additional questions that the prior forms did not. V8 stated these forms were implemented about two weeks ago. V8 stated V6 is responsible for labeling and tracking all of the slings. V8 confirmed there was no master list of slings until after R1's incident on 12/29/23. V8 stated prior to that not all of the slings were numbered and this was noted on our logs. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 1/23/24 at 12:05 PM V2 Director of Nursing stated V2 conducted the investigation of R1's 12/29/23 incident and V2 was aware that the sling strap broke during R1's transfer. V2 stated after the incident all of the full mechanical lifts and slings were inspected and a few slings were replaced, and prior to that the slings were being replaced on an as needed basis. V2 stated V2 is responsible for ordering mechanical lift slings and V2 confirmed there was no set frequency for replacing the slings. V2 stated laundry staff was responsible for checking the slings and the CNAs should inspect the slings for signs of wear when applying the sling and prior to transfers. V2 stated after R1's incident we in-serviced the nurses and CNAs on full mechanical lift transfers/slings, the facility's policy, and to check the slings prior to use.