| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145367 | A. Building<br>B. Wing | 05/21/2026 |

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| Gillespie Health & Rehab Ctr | 7588 Staunton Road<br>Gillespie, IL 62033 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement an individualized transfer plan, initiate and implement appropriate interventions for 4 of 8 residents (R20, R9, R17 and R39) reviewed for accidents in the sample of 39.The findings include:<br><br>1 On 5/20/2026 at 9:02AM V24 Certified Nursing Assistant (CNA) and V23 CNA transferred R20 from wheelchair to bed with mechanical lift. Prior to transfer R20 sitting in wheelchair with sling in place. After attaching sling straps to the lift. V23 CNA operated the lift. V24 held on to sling and V24 placed her right foot on bar underneath wheelchair that attaches to wheel of wheelchair.<br><br>R20's Minimum Data Sheet (MDS) dated [DATE] documents R20 is cognitively intact with a Brief Interview of Mental status (BIMS) of 15. R20's MDS documents R20 is dependent on staff for chair to bed transfer.<br><br>R20's care plan dated 10/20/2025 document R20 needs assistance with Activities of Daily Living (ADL's) related to limited Range of Motion (ROM) to bilateral shoulders as well a muscle weakness and wasting. R20's care plan documents intervention 10/20/2025 transfer- mechanical lift. R20's care plan fails to document any instructions of how to transfer R20 with the mechanical lift.<br><br>R20's undated face sheet documents in part a diagnosis of spinal stenosis, thoracic region, other intervertebral disc degeneration, thoracic region.<br><br>On 5/18/2026 at 9:28AM R20 in her room in bed with hospital gown on with hob (head of bed) elevated. R20 stated back in September she was being transferred from the chair to bed by 2 CNA's. R20 stated one of the CNA's was not very attentive. R20 stated one CNA was messing with the blinds and the other CNA was mad at other CNA and yelling at her. R20 stated the chair was flipped backwards during mechanical lift transfer. R20 stated she did not fall out of the wheelchair or hit the floor. R4 stated she was 4 inches from the floor. R4 stated this caused pressure on her tailbone. R20 stated she required the use of numbing cream to her tailbone. R20 stated she does not remember the name of the staff. R20 stated the staff need to be trained.<br><br>05/19/2026 3:08 PM V20 CNA stated when transferring R20 from the chair to the bed you have to hold foot on the chair or the chair will also be lifted with the lift. V20 stated R20 needs a bigger chair.<br><br>On 5/20/2026 at 9:04AM V24, CNA stated she placed her foot on the bar on wheelchair to keep the wheelchair in place.<br><br>The facility compliance incident documentation, undated documents R20 made a complaint to internal<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | compliance consulting on the evening of 9/20//2026.In the report R20 stated 2 CNAs were assisting in moving R20. R20 stated the individual in charge of steadying the wheelchair was unable to assist in getting R20 up and into it from the mechanical lift. The report documents R20 stated the lift operator became flustered and began yelling. R20 further stated that the staff responsible for the wheelchair was looking out the window and not paying attention.<br><br>The facility corrective action plan completed by V1, Administrator on 9/25/2026 documents issue/problem; while staff were attempting to transfer R20 from her w/c (wheelchair) to bed with total lift the wheelchair was tipping. Staff lowered R20 back down in wheelchair twice and then went to get the nurse to help with the transfer. The plan documents root cause evaluation: resident too large for her wheelchair and refuses to let the facility get her a larger one. The corrective action plan documents action steps: discuss with resident about getting a bigger chair and she declines. Talked with staff and re-educated new employee on transfers and personally trained employee on how to transfer resident out of wheelchair with total lift to bed on 9/24/2025. The corrective action plan documents improvement benchmarks and timeframe; for staff to properly transfer R20 from wheelchair to bed when they work on 9/25/2025.<br><br>On 5/19/2026 at 1:41PM V1, administrator presented staff training dated 10/26/25 CNA October 2025 meeting including safe handling policy. V1, administrator was asked by surveyor how this training benefited staff when R20 required different plan for the transfer due to her chair. V1 administrator stated, I personally retrained the 2 staff she had a problem with and had them do a return demonstration.<br><br>On 5/20/2026 at 4:01 PM V30 CNA stated I was a new employee I think it was my first day. I did not know you were supposed to hold R20's wheelchair so it would not come up with the lift. V30 stated she had not been trained on transfers on R20 prior to transferring R20.<br><br>The facility policy safe handling dated 7/1/23 documents to provide staff guidance on promoting resident safety through safe resident handling/transfers. The policy documents In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. The policy documents it is the responsibility of all nursing staff to know the safe handling policy and procedures. The policy documents resident safety, dignity, comfort and medical condition will be Incorporated Into goals and decisions regarding the safe lifting and moving of residents. The policy documents Nursing staff, in conjunction with the rehabilitation staff, shall assess Individual residents' needs for transfer assistance on an ongoing basis. The policy documents staff will document resident transferring and lifting needs in the care plan.<br><br>2. R9's Care Plan, dated 2/5/24, documents that R9 is at risk for falls and injuries r/t (related to) Medications: Cardiovascular Meds/Pain Meds. Medical Factors: metabolic encephalopathy, HTN, arthritis, sciatica, spinal stenosis, muscle weakness, requires wheelchair for mobility. It also documents 10/2/2024 Assess toileting needs. 11/05/2025- educate staff on keeping foot pedals and foot board on while in wheelchair. 01/30/2025- Dysum placed to seat of wheelchair.<br><br>R9's Minimum Data Set, dated [DATE], documents that R9 is cognitively impaired and dependent on staff to transfer.<br><br>R9's Fall Assessment, dated 4/6/2026, documents that R9 is at high risk for falls.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R9's F/U (follow up) Occurrence Note, dated 5/18/2026 at 10:25 AM, documents Note Text: Incident Note: Resident was observed on the floor by state surveyor, this writer was told, then gathered assistance, assessed resident for pain, collected vitals, don (Director of Nursing) was present and admin (Administrator) was notified. Poa (Power of Attorney) was called, and MD (doctor) was made aware. resident was sent to ER (emergency room) for eval.<br><br>R9's Incident report, dated 11/5/2025, documents that R9 slid to floor attempting to stand. It also documents that cause of fall was due to staff not having interventions in place with staff being educated about keeping foot pedals and foot board on while in wheelchair.<br><br>R9's Incident report, dated 5/18/2026, document that R9 was found on floor. It also documents that the root cause was determined to be resident attempting to transfer self.<br><br>R9's Health Status Note, dated 5/18/2026 at 5:00 PM, documents that Note Text: Resident returned to this community from the hospital with no new orders.<br><br>R9's Health Status Note, dated 5/19/2026 at 5:32 AM, documents that Note Text: IDT (interdisciplinary) team met, and root cause of fall determined to be resident attempting to transfer self. Immediate intervention put into place for res (resident) to have pressure pad alarm for bed/chair (may use pull tab alarm is pressure pad alarm is not available). POA (power of attorney) notified.<br><br>On 5/18/2026 at 10:22 AM observed R9 on floor knees bent. R9 head and upper body under over bed table and feet wheelchair wrapped in catheter tubing. R9 complained of neck pain and left arm pain. No dycem observed in wheelchair seat or foot board in place to foot pedals.<br><br>On 5/21/2026 at 8:50 AM V2, Director of Nursing (DON), stated that she is familiar with R9's falls and interventions put in place. V2 stated that the interventions are put in place to prevent falls. V2 stated that if the interventions are not in place, it will cause the resident to fall. V2 stated that she was in the room performing assessment and observed the fall interventions not in place. V2 stated that the interventions in place would've prevented the fall. V2 stated that staff have been educated.<br><br>On 5/21/2026 at 9:50 AM V16, Certified Nurse Assistant (CNA), stated that they are in serviced on fall interventions after each fall. V16 stated the interventions are to always be in place.<br><br>3. R39's admission Record, dated 5/20/26, documents R39 was admitted to the facility on [DATE] with diagnosis of lateral sclerosis, spinal stenosis, repeated falls, cerebral ischemia, Type 2 diabetes mellitus (DM), hypertension (HTN).<br><br>R39's Care Plan, dated 2/21/26, documents R39 is at risk for falls and injuries related to Medications: Psychotropic meds/Diuretic meds/Cardiovascular Meds/Pain Meds. Medical Factors: weakness, falls, impaired balance/gait/mobility. Interventions: 2/21/26: Orient to room, provide adequate lighting, 3/15/26- slipper nonskid socks. 3/29/26- Encourage resident to lay down after meals. R39 needs assistance with ADLs related to weakness, falls, impaired balance/gait/mobility. Interventions: Toilet Use: One-person physical assist required, Ambulation: One-person physical assist required, uses adaptive devices wheelchair, transfer: One-person physical assistance required.<br><br>R39's MDS, dated [DATE], documents R39 has a moderate cognitive impairment and requires partial to substantial assistance for ADLs. R39 requires supervision/touching assistance for mobility and transfers.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Facility's fall log for past 6 months, documents R39 has had falls on 10/23/25, 3/15/26, and 3/29/26.<br><br>R39's Health Status Note, dated 10/24/25 at 12:59 PM, documents IDT (interdisciplinary team) team met, and root cause of fall determined to be resident up with regular socks on. Immediate intervention is put into place for resident to wear grippy socks when not wearing shoes as res (resident) will allow. POA (power of attorney) aware.<br><br>R39's admission Fall Risk Assessment, dated 8/22/25, documents R39 was a Low fall risk.<br><br>R39's Fall Risk Assessment, dated 10/25/25, documents R39 was a High fall risk.<br><br>R39's Fall Risk Assessment, dated 2/21/26, documents R39 was a Low fall risk.<br><br>R39's Fall Risk Assessment, dated 3/16/26, documents R39 was a High fall risk.<br><br>R39's Fall Risk Assessment, dated 3/30/26, documents R39 was a High fall risk.<br><br>On 5/18/26 at 9:30 AM, R39 was seen sitting in her wheelchair in her room, call light seen in the bed. R39 stated she uses her walker with staff assistance, uses walker to get to her restroom. R39 stated one staff member assists her using a gait belt. R39 stated she slipped and fell a month or two ago. There is a star taped on R39's door frame indicating she is a fall risk.<br><br>There was no new intervention placed after R39's fall on 10/23/25.<br><br>4. R17's admission Record, dated 5/20/26, documents R17 was admitted to the facility on [DATE] with diagnosis of Alzheimer's disease, polymyalgia rheumatica, cervical disc degeneration, cerebrovascular disease, arthropathy, chronic kidney disease-stage 3, generalized anxiety disorder.<br><br>R17's Care Plan, dated 8/22/25, documents R17 is at risk for falls and injuries related to Medications: Psychotropic meds/Diuretic meds/Cardiovascular Meds/Pain Meds. Medical Factors: Dementia, lack of safety awareness, impaired memory. Interventions: 8/22/25: Ensure proper footwear when ambulating, instruct resident to avoid sudden position changes, orient to room, provide adequate lighting. R17's Care Plan, dated 5/15/26, documents R17 has an alarm pressure pad, may use pull tab alarm if pressure pad alarm not available in a place for my safety related to high fall risk and lack of safety awareness. interventions: Apply recommended alarm - pressure pad alarm, may use pull tab alarm if pressure pad alarm is not available, attempt to discontinue the use of my alarm when my condition allows, check placement and function of my alarm every shift and PRN (as needed), evaluate use of alternative interventions that may be put in place instead of alarms as my condition allows, perform alarm assessment quarterly and as needed, replace batteries to alarms as required.<br><br>R17's MDS, dated [DATE], documents R17 has a severe cognitive impairment and requires partial/moderate assistance for ADLs, and requires supervision/touching assistance for transfers.<br><br>Facility Fall Log for past 6 months, documents R17 as having falls on 1/11/26, 2/1/26, and 3/18/26.<br><br>R17's Physician Order, dated 5/15/26, documents Device: Alarm: Bed and Chair Alarm - pressure pad alarm, may use pull tab alarm if pressure pad alarm not available. Check for placement and functioning every shift. Every shift for high fall risk/lack of safety awareness.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R17's admission Fall Risk Assessment, dated 8/22/25, documents R17 was a Low fall risk.<br><br>R17's Fall Risk Assessment, dated 1/12/26, documents R17 was a Low fall risk (after the fall on 1/11/26).<br><br>R17's Fall Risk Assessment, dated 1/18/26, documents R17 was a High fall risk.<br><br>There was no Fall Risk Assessment completed after the fall on 2/1/26.<br><br>R17's Fall Risk Assessment, dated 3/19/26, documents R17 is a High fall risk.<br><br>R17's Health Status Note, dated 2/3/26 at 10:33 AM, documents IDT team met, and root cause of fall determined to be resident slipped by his bed, immediate intervention put into place for res to have nonskid strips on floor by his bed.<br><br>On 5/18/26 at 10:13 AM, R17 seen getting pushed out of his room by hospice and placed at the nurses desk, fall alarm seen on R17's wheelchair but it was not flashing, indicating that it was on, there were no nonskid strips on his floor.<br><br>On 5/19/26 at 4:00 PM, R17 lying in bed, fall mat on side of bed, alarm was seen under R17 but it was not flashing, indicating that it was on. There are no slip strips on the floor by the bed or in the restroom.<br><br>On 5/20/26 at 2:45 PM, V30, CNA, stated We have two types of alarms, one is a pressure alarm, and it goes off when a resident lifts their body off, the other is a tab alarm and is clipped to resident's clothing and when they stand up, it pulls the tab off and alarms. Both of them should be flashing if they are turned on. If they are not flashing, then they are either turned off or the battery went dead.<br><br>On 5/21/26 at 9:35 AM, V2, DON, stated I would expect all staff to follow fall precautions for residents who are high fall risk to keep them safe. I would also expect the staff to do fall risk assessments after every fall or change in condition, and to enter a new fall intervention after each fall.<br><br>On 5/21/26 at 10:18 AM, V24, CNA, stated they have a fall book at each nurse's station that has everyone who is a fall risk. V24 stated they are supposed to review the book at the start of their shift and sign it off that they reviewed it. V24 stated this book will have any new interventions or information about a resident in it.<br><br>The facility's Resident Council Meeting minutes, dated 7/1/25, documents in part Resident inquired as to if hourly bed checks could be done to ensure safety. Administrator informed Activity Director that laundry, dietary, nurses, aides, housekeepers, and more are making frequent checks on the hall. No hall is ever left without supervision and oversight.<br><br>The facility's Resident Council Meeting minutes, dated 3/2/26, documents in part Residents are concerned that staff keep raising the bed, making it hard to get up.<br><br>The facility's Fall Prevention Program/Protocol Policy, dated 7/1/23, documents in part Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | complications from falling. 1. The interdisciplinary will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk (based on the falls assessment results) or with a history of falls. s. If falling recurs despite initial interventions, staff will implement additional or different interventions, discontinue ineffective interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, the team will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. The resident, and/or responsibility, the physician and therapy department may be involved in the process for a holistic evaluation. 7. The team shall identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. 8. Position-change alarms will not be used as the primary or sole Intervention to prevent falls but rather will be used to assist the staff In identifying patterns and routines of the resident. The use of alarms will be monitored for efficacy and staff will respond to alarms in a timely manner. Early Prevention and Fall Risk detection: 1. New admissions shall be reviewed for fall history and interventions shall be put in place prior to admission to the facility. 2. Fall Risk Assessments shall be completed upon admission, quarterly, and with any significant change or fall. S. Resident's individualized fall interventions shall be accessible to all staff for quick review in a Fall Binder at each nurse's station. 6. Resident found to be at High Risk, scoring 10 or higher on Fall Risk Assessment, shall have a visual identifier on room door and on assistive/mobility device to alert staff of the fall risk. |