

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/24/2024
NAME OF PROVIDER OR SUPPLIER Gilman Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31642</p> <p>Based on observation, interview and record review the facility failed to provide Activities of Daily Living (ADL's) assistance, to maintain residents dignity for two of 25 residents (R25 and R46) reviewed for dignity on the sample list of 25.</p> <p>Findings include:</p> <p>1.) R46's Diagnoses Sheet dated 3/19/24 documents the following diagnoses:</p> <p>Unspecified Dementia, Unspecified Severity With Agitation, Cognitive Communication Deficit, Unspecified Lack of Coordination, and Difficulty in Walking Not Elsewhere Classified.</p> <p>R46's Minimum Data Set (MDS) dated [DATE] documents R46's Brief Interview of Mental status score of four out of a possible 15, which indicates severe cognitive impairment. The same MDS does not document any behaviors directed to self or others.</p> <p>R46's Care Plan dated 3/19/24 documents the following: Resident has an ADL (Activity of Daily Living) Deficit, Self-care performance deficit r/t (related/to) impaired balance. Intervention: Encourage the resident to participate to the fullest extent possible with each</p> <p>interaction.</p> <p>R46's Task Certified Nursing Assistants sheet dated May 11- May 23, 2024 documents:</p> <p>Dressing Self Performance - How resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or (name brand compression) hose. Dressing includes putting on and changing pajamas and housedresses. There was no documentation on 5/21/24, on any shift. R46 had extensive assistance with dressing 11 shifts of 19. R46's same Task documentation has a column for resident refusal of assistance. There are no refusals with dressing documented.</p> <p>R46's Restorative Nursing Evaluation dated 5/24/24 documents the following:</p> <p>Self-Care: Code the resident's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Needed Some Help - Resident needed partial assistance from another person to complete activities.</p> <p>On 5/21/24 at 11:35, R46 was seated in a stationary chair in clear view of the hallway. R46 had no pants on. R46 had bare legs. R46's incontinence brief was on full display of anyone that passed R46's wide-opened door.</p> <p>On 5/21/24 at 11:38 am V7, Certified Nursing Assistant (CNA) acknowledged R46 did not have on pants and was in clear view of other residents and staff in the hall. V7, stated R46 should have on pants, but laundry department never have pants for R46.</p> <p>On 05/21/24 at 12:00 pm, R46 remains seated in a stationary chair in her room. R46 has no pants on. R46 remained seated in only an incontinence brief. R46's bedroom door remained wide opened. R46 was in clear view of unidentified residents that were being assisted by unidentified staff, down past R46's room and into the dining room.</p> <p>On 5/21/24 at 1:20 pm as unidentified residents returned to their rooms from the dining room, they passed R46's room. R46 bedroom door remained wide open. R46 was visible to the hall with only an incontinence brief on, and legs bare. R46 had no pants on. V9, Activities Assistant, entered R46's room with V10 and V11, Facility Visitors and a dog. R46 remained seated in stationary chair with incontinence brief on, no pants and bare legs.</p> <p>On 5/21/24 at 1:25 pm, as V10 and V11, Visitors exited R46's room, V2, Director of Nursing (DON) entered R46's room. V2, DON confirmed R46 had no pants in her closet, room or bathroom, and was in clear view of the hall way while seated in R46's bedroom stationary chair. V2 confirmed it is a dignity issue to set in clear view people in the hall, without appropriate clothes on.</p> <p>On 5/21/24 at 1:35 pm V7 and V8, CNA's were together in R46's room to assist R46 with toileting and dressing. V7 and V8 stated they provided incontinence care for R46 before lunch around 11:30 am, but did not have pants to put on R46. V7, CNA then stated (R46) has no pants because laundry service is terrible here. We did not have pants to put on her.</p> <p>32172</p> <p>2. R25's Medical Diagnoses List dated May 2024 documents R25 is diagnosed with Palliative Care, Depression, Alzheimer's Disease, Dementia, Mood Disorder, and Restlessness and Agitation.</p> <p>R25's Physician Order Sheet dated May 2024 documents R25 is to have a regular diet with a thin/regular consistency and fortified foods: cereal in the AM, mashed potatoes at noon, and pudding in the PM.</p> <p>R25's Minimum Data Set, dated dated dated [DATE] documents R25 is severely cognitively impaired and requires partial/moderate assistance with eating.</p> <p>R25's Care Plan dated 5/21/24 documents R25 is at risk for altered risk of nutrition and had a poor appetite. R25's Care Plan does not address her refusal to use utensils and that R25 routinely feeds herself with her fingers.</p> <p>(continued on next page)</p>

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/24 at 12:09 PM R25 was eating cooked carrots, cooked cabbage, meat, and pudding with her fingers. She had food all over her fingers and routinely dropped food debris on her chest and chin.</p> <p>On 5/21/24 at 12:09 PM V17 Licensed Practical Nurse stated R25 always eats with her fingers. V17 stated R25 refuses assistance with eating and refuses to use silverware.</p> <p>On 5/24/24 at 10:45 AM V3 Registered Nurse confirmed R25 eats with her fingers and doesn't like to use silverware. V3 confirmed the staff should attempt to encourage R25 to use silverware or assist her with eating if she will allow them. V3 confirmed R25's eating preferences should be documented in her Care Plan with relevant interventions and her diet should be updated to include food items that are more finger friendly.</p> <p>The facility's Quality of Life - Dignity policy dated October 2009 documents each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Each resident will be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32172</p> <p>Based on observation, interview, and record review the facility failed to routinely provide oral hygiene for one of one resident (R25) reviewed for oral care on the sample list of 25.</p> <p>Findings Include:</p> <p>The facility's Oral Care policy dated 4/2/24 documents it is the facility's practice to provide oral care to residents in order to prevent and control plaque-associated oral disease.</p> <p>R25's Medical Diagnoses List dated May 2024 documents R25 is diagnosed with Palliative Care, Depression, Alzheimer's Disease, Dementia, Mood Disorder, and Restlessness and Agitation.</p> <p>R25's Minimum Data Set, dated dated dated [DATE] documents R25 is severely cognitively impaired and requires substantial/maximum assist for oral hygiene.</p> <p>R25's Care Plan dated 5/23/24 documents R25 is not accepting of oral care and is verbally and physically abusive towards staff during this task.</p> <p>On 5/21/24 at 12:09 PM R25's teeth appeared filled with food debris. Her gums were reddened and appeared inflamed.</p> <p>On 5/23/24 at 11:49 PM R25's teeth appeared filled with food debris. Her gums were reddened and appeared inflamed.</p> <p>On 5/23/24 at 11:45 AM V21 Certified Nurses Assistant stated R25 often refuses to have her teeth brushed. R25 will bite down on the toothbrush. V21 stated she has not brushed R25's teeth today because she refused.</p> <p>On 5/24/24 at 10:45 AM V3 Registered Nurse confirmed R25 refuses to get teeth brushed but staff should document accordingly and document refusals for care. Staff should be attempting to brush R25's teeth and assist with oral hygiene. Staff should re-approach R25 and attempt to use alternative methods to get the job done.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>35347</p> <p>Based on observation, interview, and record review, the facility failed to maintain a resident toilet and bed position remote control cable in a safe and repaired condition. These failures have the potential to affect three residents (R4, R14, R31) of four reviewed for safety in the sample list of 25.</p> <p>Findings include:</p> <p>1. R4's diagnosis list (5/24/2024) documents diagnoses including: Difficulty in Walking, Intellectual Disabilities, Morbid Obesity, and Dementia.</p> <p>R4's quarterly assessment (3/28/2024) documents R4 uses a walker for mobility and is frequently incontinent of bowel and bladder.</p> <p>R4's Fall Risk Assessment (3/28/2024) documents R4 has poor vision, is ambulatory, and has balance problems when standing.</p> <p>R4's Care Plan (5/23/2024) documents R4 is at risk for falling.</p> <p>On 5/21/2024 at 1:35PM, R4 reported using the shared toilet located between R4's room and the adjacent resident room. R4 reported being concerned about the toilet moving around when R4 sits on the toilet and R4 reported having to sit very still while using the toilet to keep the toilet from moving. R4 reported the toilet had been moving around on the floor for a long time.</p> <p>2. R31's diagnosis list (5/14/2024) documents diagnoses including: Abnormality of Gait and Mobility, Epilepsy, Convulsions, History of Falling, and Intellectual Disabilities.</p> <p>R31's Physician Orders (5/24/2024) documents R31 takes blood thinner medication daily.</p> <p>R31's quarterly assessment (3/19/2024) documents R31 is frequently incontinent of bowel and bladder.</p> <p>R31's Fall Risk Assessment (3/19/2024) documents R31 has a history of falls, has poor vision, is ambulatory, and has balance problems while standing or walking.</p> <p>R31's Care Plan (5/24/2024) documents R31 is at risk for falls and at risk for bleeding due to blood thinner medication use.</p> <p>On 5/23/2024 at 12:25PM, R31 was non-verbal. R31 nodded R31's head in a yes motion when asked if R31 used the toilet in the bathroom attached to R31's room. When asked if the toilet was moving around on the floor surface during use, R31 nodded yes. When asked if the toilet had been unstable for a long time, R31 again nodded yes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/21/2024 at 1:35PM, R4 and R31's bathroom toilet appeared crooked and poorly fastened to the floor. When the base of the toilet was gently nudged, the entire toilet basin and attached tank easily rotated on the floor 20 or more degrees to the left or right of center. The toilet easily tipped forward and backwards when light to moderate pressure was applied to the front of the toilet basin.</p> <p>On 5/21/2024 at 12:40PM, V14 (Certified Nurse Aide) reported R4 will use the above toilet independently. V14 observed the toilet and stated Oh my and reported the toilet was not safe for resident use. V14 reported R31 also uses the same toilet independently and is at risk for falls.</p> <p>On 5/24/2024 at 11:50AM, V22 (Maintenance Director) reported the the bracket attaching the above toilet to the floor was partially rusted out, allowing the the toilet to move around on R4 and R31's bathroom floor.</p> <p>3. R14's comprehensive assessment (2/26/2024) documents R14 has severe cognitive impairment, upper/lower extremity impairment limiting range of motion, is always incontinent of bladder, and has the diagnosis of Epilepsy (seizure disorder).</p> <p>On 5/21/2024 at 1:25PM, R14 was sleeping in bed with R14's remote bed control adjacent to R14's body. The bed remote cable was badly damaged with the outer cable insulation missing on several sections of the cable and unraveling electrical tape was partially wrapped around one portion of the missing wire insulation.</p> <p>On 5/22/2024 at 11:44 AM, the above cable remained damaged on R14's bed remote and the sharp corner of a plastic cable tie was protruding through a portion of the unraveling electrical tape.</p> <p>On 5/24/2024 at 11:50, V22 (Maintenance Director) viewed the damaged cable and reported the cable for sure needed to be repaired.</p>

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<p>F 0868</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>31642</p> <p>Have the Quality Assessment and Assurance group have the required members and meet at least quarterly</p> <p>Based on record review and interview the facility repeatedly failed to ensure that a designated key member (Infection Control Preventionist) of the committee was present at their quarterly Quality Assurance (QA) meeting. This has the potential to affect all 56 residents that reside in the facility.</p> <p>Findings include:</p> <p>On 5/21/24 at 3:25 pm the facility provided an undated facility Quality Assurance and Performance Improvement Program (QAPI) policy that documents the following: The facility Administration is responsible to oversee that the facility to ensure Quality Assurance and Performance Improvement Committee (QAPI) , meet monthly at minimum and includes the following key members: The facility Director of Nursing, Medical Director or other designated Physician, Infection Control Preventionist, Staff responsible for the facility plant and three additional staff member responsible for direct patient care and services.</p> <p>The facility provided the attendance sign-in sheets with the QAPI policy noted above. The sign in sheets included all QA committee meetings held since last annual 7/14/24. The facility QA meeting sign-in sheets were dated 7/28/23, 9/15/23, 11/03/23, 12/08/23, 1/26/24, 2/23/24, 3/22/24, and 4/26/24. The signatures on the QA meeting sign-in sheets, did not include the required (V3, Registered Nurse) Infection Control Preventionist.</p> <p>On 05/22/24 at 09:20 am V3, Registered Nurse/Infection Control Preventionist stated V3 has been the Infection Control Preventionist for one year. V3 provided V3's Nursing Home Infection Preventionist Training Course Certificate dated 6/21/23. V3 stated she has not attended the QA committee meetings, because she did not know she was required to do so.</p> <p>On 5/22/24 at 9:25 am V1, Administrator acknowledged V3, Infection Control Preventionist did not attend any QA committee meeting in the past year as required.</p> <p>The facility Long-Term Care Facility Application for Medicare and Medicaid dated 5/21/24 documents the facility total resident census as 56.</p>		