

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/19/2025
NAME OF PROVIDER OR SUPPLIER Gallatin Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 900 West Race Street Ridgway, IL 62979	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to ensure dishes and utensils were properly washed/sanitized and food/drinks were covered /dated to prevent cross contamination. This failure has the potential to affect all 37 residents residing in the facility. Findings Include: On 9/16/25, during the initial walk through of the kitchen that occurred between 9:30 AM and 10:00 AM two cups of frozen ice cream were left uncovered and not labeled in the freezer. At this same time a tray full of beverages were found in the reach in refrigerator not covered nor dated/timed. During this same initial tour the dish machine was found to have no sanitizer registering on the chlorine test strip. V3 (Dietary) stated at this time that she had not been able to get any sanitizer to register on her test strip this morning either and couldn't figure out what to do. V3 went on to state that they have been having issues with the dish machine for over a week now and it has been worked on in attempt to get the sanitizer to dispense properly. V3 stated that they have been using the dish machine this morning even though no sanitizer was in registering on the test strip. On 9/16/25 at 10:45 AM during a follow up visit to the kitchen the staff were using the three-compartment sink to wash, rinse and sanitize the dishes. At this time V4 (Dietary) was asked to check the sanitizer level in the sink. V4 provided surveyor with quat (Quaternary Ammonium) strips, and two strips were checked, and no sanitizer was registering. V4 then made new sanitizer water and the level and check and checked it to ensure that it was within recommended range. V4 stated at this time while making the new sanitizing solution how the measurements of water and sanitizer are mixed. V4 stated that the machine does the mixing of the solution into the water ran into the sink. V4 stated that there is no water fill line, you just fill the sink to where they think it should be and then use the strip to check the level. On 9/17/25 at 10:30 AM, V5 (Dietary Manager) stated that all items should be covered and labeled with what it is and dated in the refrigerator and freezer. V5 also stated that when the dish machine does not work/sanitize they should be using the three-compartment sink. A policy for Pot and Pan Washing with a revision date of 12/30/24 documents Policy Interpretation and Implementation 3. The third sink will be filled to the designated line with warm water (not less than 75 degrees) and two pumps (two fluid ounces) of sanitizer from the dispenser over the sink. A solution of sanitizer at the rate of 200 PPM (Parts Per Million) is necessary. Pots should remain in the solution for not less than one minute. A policy and procedure titled Food Storage area with a revision date of 12/30/24 documents 5. prepared food stored in the refrigerator until service shall be dated. Such foods will be tightly sealed with plastic wrap, foil or a lid. The Long-Term Care Facility Application for Medicare and Medicaid form dated 9/16/25, documents that there are 37 residents residing in the facility.		

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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to ensure the safety of 1 (R20) of 2 residents reviewed for smoking in a sample of 25. Findings include: R20's admission Record documented an admission date of 4/12/22 with diagnoses including: cerebral infarction, expressive language disorder, dysphagia following cerebral infarction. R20's 7/10/25 Minimum Data Set (MDS) documented .Should a Brief Interview for Mental Status (BIMS) be Conducted? with the code .0. No (resident is rarely/ never understood). R20's Electronic Medical Record (EMR) documented no Smoking Evaluation Assessment since the 7/8/24 Smoking Evaluation Assessment documenting .E. Has resident had any safety issue in the past related to smoking (current of pervious setting)? b. No. G. Resident is able to safely handle lit smoking materials? . a. Yes. I. Does resident have clothing with burn holes? b. No. K. Does resident wear a smoking apron? b. No. If resident does not wear a smoking apron, is one needed? b. No. Care plan reviewed and revised for appropriate supervision and smoking directions to include: b. General Supervision. R20's Care Plan Report documented a created 6/2/22 Focus of .(R20) is a smoker. with the only Intervention/ Tasks created 6/2/22 . (R20) was given a schedule with facility scheduled smoke times. On 9/16/25 at 10:08 AM, R20's jacket was hanging on the bathroom door in his room and was observed to have multiple burn holes in it. On 9/18/25 at 1:08 PM, R20 wheeled himself outside to smoke wearing the jacket with multiple burn holes and a pair of pajama pants with multiple burn holes. R20 was giving 2 cigarettes by a staff member. R20 held the cigarette between his thumb and index finger with the ignited end closest to the palm of his hand. When R20 lowered the cigarette the ignited end of the cigarette was positioned toward his body and clothing. R20 was observed to have his cigarette almost touching his pants and bumping the plastic cushion of R20's wheelchair. On 9/18/25 at 1:20 PM, V7 (Regional Director of Operations) said the Interdisciplinary Team (IDT) should complete a smoking assessment quarterly and R20 should have interventions in place for safe smoking. V7 said he was not sure why R20 would not have interventions in place due to all the burn holes in R20's clothing. The facility's 2025 Resident Smoking Policy and Procedure documented in part . A. Each resident should be individually assessed to determine whether or not he/she can safely smoke without supervision. The facility shall conduct an assessment to determine whether the resident requires a smoking apron and shall document this in the resident's care plan. Reassessments should be conducted, as necessary. The determination should be noted in the resident's care plan and in a smoking log to be kept on each residential floor.		