DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		145347	B. WING				C 10/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER			390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	FC	000			
F 157 SS=D	Complaint #166120 483.10(b)(11) NOT (INJURY/DECLINE	IFY OF CHANGES	F 1	157			
	consult with the res known, notify the re or an interested fan accident involving ti injury and has the p intervention; a signi physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of trea consequences, or ti treatment); or a deo	ediately inform the resident; ident's physician; and if esident's legal representative nily member when there is an he resident which results in potential for requiring physician ificant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial threatening conditions or ns); a need to alter treatment need to discontinue an atment due to adverse o commence a new form of cision to transfer or discharge he facility as specified in					
	and, if known, the ro or interested family change in room or r specified in §483.1 resident rights under	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or sified in paragraph (b)(1) of					
	the address and ph	cord and periodically update one number of the resident's or interested family member.					
		NT is not met as evidenced					
LABORATORY	UIRECIOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NALURE		TITLE		(X6) DATE

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.

		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES	(V2) MU	тірі	LE CONSTRUCTION		0938-0391
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				(-)	PLETED
						(C
		145347	B. WING			03/*	10/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER			390 SOUTH CRESCENT STREET, BOX 307		
				Ģ	GILMAN, IL 60938		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	Y	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
			1		DEFICIENCY)		
F 157	Continued From no		–				
F 157	Continued From pa	gei		57			
	by: Based on record re	eview and interview, the facility					
		primary care physician and					
	family of skin break	down for one of three					
		ewed for notification of change					
	in the sample of thr	ee.					
	Findings Include:						
	R1's undated face s	sheet lists the following					
	Diagnoses: Pressu	re Ulcer and Venous					
	Insufficiency.						
	B1's MDS (Minimur	m Data Set) dated 10-29-15					
		everely cognitively impaired.					
		m, Z1 (R1's POA (Power of					
		R1) was discharged from the					
		nd came to live with me. (R1) In the foot. The facility never					
		The only open area that I was					
	aware that (R1) had	d was on the buttocks, they					
	called and told me a	about that, but it was healed."					
	B1's Progress Note	es dated 10/22/15 at 4:37 pm					
	by E7 LPN (License						
		dmitted to facility via van from					
		s an area above (R1's) inner					
		easures 3 cm (centimeters) by					
		d red in color with slight 'ound Nurse Notified." There is					
		of Z2, Primary Physician, or Z1					
		's wound or a treatment					
	request.						
	R1's Progress Note	es dated 10/23/15 at 3:22 pm					
		red Nurse) documents, "scabs					
	on heels." There is	no documentation of Z1 or Z2					
	being notified of the	ese scabs.					

If continuation sheet Page 2 of 15

		AND HUMAN SERVICES				FORM	APPROVED
	<u>RS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES		חיד	LE CONSTRUCTION	1	0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
			N. BOILD		•		С
		145347	B. WING				- 10/2016
NAME OF F	PROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER		1390 SOUTH CRESCENT STREET, BOX 307			
<u> </u>			l	0	GILMAN, IL 60938		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
	l				DEFICIENCY)		
F 167			j				
F 157	Continued From pa	ge 2	F 1	57	·		
	R1's Progress Note	es dated 11/2/15 by E3, Wound					
		"(Z3 Wound Physician), here				l	
	today to see (R1) a	nd right heel blister stage II				l	
		ft heel blister, and right ball of				l	
		inner ankle." There is no 1 or Z2 being notified of these				l	
	pressure ulcers.					l	
	•						
		m, E7 stated, "I was the nurse					
		(R1) had a sore on the right was no treatment ordered. I let					
		(E3) is the one that gets a				l	
		or treatment orders. I did not				l	
	call (Z1) or (Z2) and	d update date them on the				l	
	open area."					l	
	On 3/9/16 at 11:15	am, E6 stated, "when I saw					
		admission, (R1) had what					
	looked like black e	schar {hard covering/scab} on					
		mately 1cm by 1 cm. I didn't				l	
		ne area because it wasn't open					
		re when it is an open area. cm by 0.5 cm eschar area to					
		ea. (R1) didn't have treatment					
		ne one that gets the treatment					
		ound Physician). I assumed					
		n getting orders. Occasionally					
		skin issues, (E3) will tell us to to to but normally (E3) just					
		ny orders. I did not call (Z1) or					
		on (R1's) scabbed areas."					
		sment dated 11/2/15 for R1 eel Pressure Ulcer Stage II - 6					
		Heel Pressure Ulcer Stage II -					
		t Ankle - 2 cm by 1.5 cm, and					
	Right first Metatars	al Stage II - 4 cm by 3 cm.					

Facility ID: IL6003578

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STATE SUPPLY PERVIDERSUPPLENCIAL IDENTIFICATION NUMBER: VALUENCIAL A BULDING VALUENCIAL A BULDING VALUENCIAL A BULDING VALUENCIAL A BULDING VALUENCIAL BULDING VALUENCIAL BULDIN			AND HUMAN SERVICES			FORM	03/14/2016 APPROVED 0938-0391
Index 145347 B. WING 03/10/2016 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, UP CODE STREET, BOX 307 GLIMAN HEALTHCARE CENTER SUMMARY STATEMENT OF DESCRIPTIONE STREET ADDRESS, CITY, STATE, UP CODE SUMMARY STATEMENT OF DESCRIPTIONE STREET ADDRESS, CITY, STATE, UP CODE SUMMARY STATEMENT OF DESCRIPTIONE STREET ADDRESS, CITY, STATE, UP CODE SUMMARY STATEMENT OF DESCRIPTIONE STREET ADDRESS, CITY, STATE, UP CODE STREET ADDRESS, CITY, STATE, UP CONTRESS, CITY, STATE, UP CONTRESS, CITY, STATE, UP CONTRESS, UP	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
GILMAN HEALTHCARE CENTER 1399 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938 PHEFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OBTICS THE APPROPRIATE PECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S FLAN OF CORRECTION (EACH OBTRICE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PECULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S FLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OC OWH_ETIC (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OC OWH_ETIC (EACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DIFFICIENCY F 157 There is no documentation found in R1's medical record			145347	B. WING	 		
GLIMAN HEALTHCATE CENTER GLIMAN, IL 60938 (X4) ID PHEFX TAG SUMMARY STATEMENT OF DEFICIENCIES INCOMMENT OF DEFICIENCIES PHEFX RECULATIONY ON LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTIVE ACTOR NEODED BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENT CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMMENT CROSS-REFERENCE COMMENT CROSS-REFERENCE COMMENT CROSS-REFERENCE COMMENT CROSS-REFERENCE COMMENT CROSS-REFERENCE COMMENT CROSS-CROSS-CROSS- CROSS CROSS-CROSS- CROSS-CROSS-CROSS- CROSS-CROSS-CROS	NAME OF F	ROVIDER OR SUPPLIER					
Principul TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) PREIN TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY) COMMENTIFY INTER F 157 Continued From page 3 There is no documentation found in R1's medical record that shows that Z1 or Z2 were notified of R1's wounds to the inner ankle, bilateral heels or right ball of foot area. F 157 F 157 On 3/8/16 at 8:20 am, E4 DON (Director of Nursing) stated, When a wound is found, I expect the physician to be notified and a treatment order obtained, family should also be notified." F 157 The facility Charting and Documentation Policy dated April 2008 documents, "All services provided to the resident, or an changes in the resident's medical or mental condition shall be documented in the resident's medical recorddocumentation of procedures and treatments shall include care specific details and shall include care specific details and shall include care specific details and shall include at a minimum: notification of family, pysician or other staff if indicated." F 279 F 279 A53.20(A), 483.20(K)(1) DEVELOP SS=0 F 279 F 279 A facility must use the resident's medicat dovelop, review and revise the resident's comprehensive plan of care. F 279 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and mental and psychosocial needs that are identified in the comprehensive assessment. F 279 The care plan must describe the services that are The care plan must describe the se	GILMAN	HEALTHCARE CENT	ER				
There is no documentation found in R1's medical record that shows that Z1 or Z2 were notified of R1's wounds to the inner ankle, bilateral heels or right ball of toot area. On 3/8/16 at 8:20 am, E4 DON (Director of Nursing) stated, "When a wound is found, 1 expect the physician to be notified and a treatment order obtained, family should also be notified." The facility Charting and Documentation Policy dated April 2008 documents, "All services provided to the resident, and an anti- resident's medical or mental condition shall be documented in the resident's medical recorddocumentation of procedures and treatment shall include care specific details and shall include at a minimum: notification of family, physician or other staff if indicated." F 279 SS=D COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLÉTION
to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279	There is no docume record that shows ti R1's wounds to the right ball of foot are On 3/8/16 at 8:20 a Nursing) stated, "W expect the physicia treatment order obt notified." The facility Charting dated April 2008 do provided to the resi resident's medical of documented in the recorddocumenta treatments shall inc shall include at a m physician or other si 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable	entation found in R1's medical hat Z1 or Z2 were notified of inner ankle, bilateral heels or ea. m, E4 DON (Director of /hen a wound is found, I in to be notified and a tained, family should also be g and Documentation Policy ocuments, "All services dent, or an changes in the or mental condition shall be resident's medical ation of procedures and clude care specific details and inimum: notification of family, staff if indicated." ()(1) DEVELOP E CARE PLANS the results of the assessment and revise the resident's n of care. evelop a comprehensive care ent that includes measurable stables to meet a resident's nd mental and psychosocial tified in the comprehensive				

If continuation sheet Page 4 of 15

		AND HUMAN SERVICES			FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY PLETED
		145347	B. WING			C 10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER		1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938	I	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	be required under § due to the resident's §483.10, including to under §483.10(b)(4 This REQUIREMENT by: Based on record refailed to develop a consistent one of three resident in the sample of thr Findings Include: R1's Physician Ord 3/8/16 documents F from the hospital or Dehydration and a construction from the hospital or Dehydration and a construction R1's Dehydration R 10/23/15 and 1/19/1 dehydration." R1's Care plan date R1 being at risk for Diagnosis of Dehyd staff need to monited On 3/8/16 at 11:45 (Registered Nurse/ unable to answer q dehydration diagno stated, "I wasn't em (R1) was admitted I been released from	ervices that would otherwise §483.25 but are not provided s exercise of rights under the right to refuse treatment). NT is not met as evidenced eview and interview, the facility comprehensive care plan for nt (R1) reviewed for care plans ee. er Report dated 10/22/15 - R1 was admitted to the facility, n 10-22-15 with a Diagnosis of diet order of mechanical soft nick liquids. tisk Assessment dated 16 documents "high risk for ed 11/5/15 does not document Dehydration, having a Iration, or the signs/symptoms	F 279			

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145347	B. WING				C 10/2016
NAME OF	PROVIDER OR SUPPLIER	-			TREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER			390 SOUTH CRESCENT STREET, BOX 307 ILMAN, IL 60938		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279 F 314 SS=D	 (R1) was at heighter monitoring. The facility's Hydrar liquids, put (R1) at a The facility's Hydrar October 2010 docu staff will identify ind for subsequent fluic example, those with fever, or who are ta not eating and drink. The facility's Care F dated November 20 comprehensive car measurable objectir resident's medical, psychological need residentcomprehe designed to incorpor and risk factors as problems." 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facil	ch so staff would know that ened risk and needed at that (R1) was on thickened risk, even without a diagnosis." tion- Clinical Protocol dated ments, "the physician and ividuals with a significant risk d and electrolyte imbalance; for n prolonged vomiting, diarrhea, iking diuretics and/or who are king well." Plans - Comprehensive Policy 010 documents, "an individual e plan that includes ves and timetables to meet the nursing, mental and s is developed for each ensive care plans are orate identified problem areas sociated with identified ENT/SVCS TO RESSURE SORES orehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that ible; and a resident having eives necessary treatment and e healing, prevent infection and	F 2 F 3				

If continuation sheet Page 6 of 15

		AND HUMAN SERVICES			FORM	03/14/2016 APPROVED 0938-0391
STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		145347	B. WING			C 10/2016
NAME	OF PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
GILM	AN HEALTHCARE CENT	ER		1390 SOUTH CRESCENT STREET, BOX 303 GILMAN, IL 60938	7	
(X4) PREF TAC	IX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 3	by: Based on record re failed to follow their management, and prevent further dete for one of three res pressure ulcers. The receiving pressure 11 days and R1's ri increasing in size fr to 6 cm by 4.5 cm. Findings Include: The facility's Press dated October 2010 this procedure is to care of existing pre prevention of additi pressure ulcer treat on the following strat and the pressure ul and pressure ulcer {the wound}, manage treatment per physit The facility's Press Policy dated Octobe purpose of this proof for the assessment at risk of developing common site of a p bone is near the su back of the hear are shoulder blades, ba ankles, and toes."	eview and interview, the facility policy on wound failed to follow the care plan to erioration of existing wounds idents (R1) reviewed for is failure resulted in R1 not ulcer treatments to wounds for ght heel pressure ulcers from 1 cm (centimeter) by 1 cm ure Ulcer Treatment Policy 0 documents, "The purpose of provide guidelines for the ssure ulcers and the onal pressure ulcersthe tment program should focus ategies: assessing the resident lcer, managing tissue loads, carenotify physicianprotect ge drainage, {provide}	F 314	4		

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		AND HUMAN SERVICES			FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145347	B. WING			C 10/2016
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER		390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa Insufficiency.	ge 7	F 314			
	documents R1 is se requires extensive	m Data Set) dated 10-29-15 everely cognitively impaired, assist of 2 assist for bed ers, and is non-ambulatory.				
	by E7 LPN (License documents, "(R1) a {hospital}(R1) has right ankle. Area m 1.5 cm. Wound bec discharge noted. W no documentation c	es dated 10/22/15 at 4:37 pm ed Practical Nurse) idmitted to facility via van from s an area above (R1's) inner easures 3 cm (centimeters) by d red in color with slight Yound Nurse Notified." There is of (Z2 Primary Physician) 's open wound or a treatment				
		es dated 10/23/15 at 3:22 pm red Nurse) documents, "scabs				
		essment dated 10/23/15 moderate risk for skin				
	received on 10/28/1 found}: "cleanse are ankle area, then ap Alginate and then b and change two tim needed)." There are the scabbed area's record documents t November 2015 {11 with areas present} heel and ball of righ	documents the following order 15{6 days after ankle wound is ea to right lower leg, inner ply Betadine, cover with ordered Hydrocolloid dressing ies a week and PRN (as e no orders documented for on R1's heels. R1's clinical the following order dated I days after R1 was admitted : "cleanse area to right and left at toe with Betadine,cover with cover with Alginate then				

Facility ID: IL6003578

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	-	AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COM	E SURVEY PLETED
		145347	B. WING				C 10/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER			90 SOUTH CRESCENT STREET, BOX 307 ILMAN, IL 60938		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	-	F 31	14			
	bordered Hydrocolle day) and PRN."	oid dressing QOD (every other					
	Nursing) stated, "W	m, E4 DON (Director of /hen a wound is found, I n to be notified and a btained."					
	who admitted (R1). inner ankle. There we did not see any othe Wound Nurse) know gets a hold of the d The only pressure we upon admission wa	im, E7 stated, "I was the nurse (R1) had a sore on the right was no treatment ordered. I er area of concern. I let (E3, w about it, (E3) is the one that loctor for treatment orders. ulcer intervention I initiated is a heels up for (R1) to keep bed while lying down."					
	(R1), the day after a looked like black es both heels, approxis actually measure th and we only measur (R1) also had a 0.5 the right big toes ar hard to see since (F have treatment order gets the treatment of	am, E6 stated, "when I saw admission, (R1) had what schar {hard covering/scab} on mately 1cm by 1 cm. I didn't he area because it wasn't open are when it is an open area. I cm by 0.5 cm eschar area to rea. These areas were really R1) is dark skinned. (R1) didn't ers but (E3) is the one that orders from (Z3 Wound hed (E3) was working on					
	concerns or pressu 11/2/15 by E3. E3 d see (R1) and right h opened per (Z3) an applied. Then (Z3)	es do not document any skin are ulcers from 10/23/15 until documents, "(Z3) here today to heel blister, stage II, was ad then cleansed and dressing opened left heel blister and dressing applied, the right ball					

Facility ID: IL6003578

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	-	AND HUMAN SERVICES			FORM	03/14/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COM	E SURVEY IPLETED
		145347	B. WING			C 10/2016
NAME OF	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER		1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	area blister opened applied. Area to right dressing applied. We and color consistent edges attached and amount of serous de and also wants foar bed and {offloading Arterial Doppler to b Z3's Wound Assess documents Right H cm by 4.5 cm, Left 4 cm by 3 cm, Right Right first Metatarsa On 3/9/16 at 8:50 a (R1) having an ope on 10/28/15, that is treatment order, co noticed it when (R1 why they didn't say then notified of uns (R1's) heels and bas same thing, the stat but didn't say anyth of (R1's) foot to (Z3 was seen by (Z3) o ordered at that time done to (R1's) heels days}. I don't see the informed they have informed as soon a On 3/9/16 at 9:15 a admission, the nurs precautionary skin is	age 9 I and cleansed and dressing ht inner ankle cleansed and Vound base 100% granulation ney red and adherent wound d well defined and moderate frainage noted. (R1) tolerated m boots and heels up while in boots on while in wheelchair. bilateral lower legs." sment dated 11/2/15 for R1 leel Pressure Ulcer Stage II - 6 Heel Pressure Ulcer Stage II - 6 m, E3 stated, "I was told of n area to the right inner ankle when I called (Z3) and got the me to find out staff had) was admitted. I don't know anything sooner to me. I was tageable blood blisters on all of foot on 10/29/15 and ff knew about those areas also ing sooner. I texted a picture blout (Z3) didn't respond. (R1) n 11/2/15 and a treatment was e. No treatment was being s and ball of foot until then {11 he residents unless I'm skin issues, I need to be is the problem is observed." am, E4 stated, "upon sing staff need to implement interventions, and people need s immediately so the nurse sician and the problem can be				

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		AND HUMAN SERVICES			FORM	03/14/2016 APPROVED
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	0938-0391 E SURVEY PLETED
		145347	B. WING			C 10/2016
NAME OF	PROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER		1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	addressedI don't when (Z3) didn't ret standing orders for at least activated th On 3/9/16 at 10:20 on 10/28/15 about (recommendations a I saw (R1) on 11/2/ ulcers all over, I doo Wound Assessmen between pressure a were present on ad {facility} for not calli extreme. (R1's) wo first saw them, I wa but (R1) did and wit majority of the wou told E3 stated E3 h 10/29/15 to Z3 but of stated, "If I didn't re primary responsibili could have called (Z a week to give reco stated, "My expecta do a skin swoop up appropriate prevent like (R1) who is em decreased mobility for breakdown if the done correctly, that risk and they should Mattress, an immed heel booties and of prevention."	know why staff didn't follow up turn call. We {facility} have wound care, they should have nose orders." am, Z3 stated, "(E3) called me (R1's) ankle wound and I gave and the treatment was started. 15 and (R1) had extreme cumented everything on my at, they were a mixture and vascular, all the wounds limission and bad on them ing me until they were so unds were so extreme when I asn't sure if (R1) would survive, th proper treatment, the nds actually healed." Z3 was ad sent a picture text on didn't get a response. Z3 espond, they still have a ity to treat the resident, they Z2), I'm only at the facility once ommendations." Z3 also ation is that the facility should oon admission and implement tion interventionssomeone aciated, malnourished, has and poor nutrition is high risk e Skin Risk Assessment is would put the resident at high d have an Alternating Air diate nutritional evaluation,	F 314			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		145347	B. WING				C 10/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GILMAN	HEALTHCARE CENT	ER			390 SOUTH CRESCENT STREET, BOX 307 iILMAN, IL 60938			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314 F 514 SS=D	DON) that (Z3) felt looked and should long." R1's Care Plan date is at risk for pressur under weight and { with initial interventi skin during position conduct a systemat keep clean and dry dry and wrinkle free breakdown, use hee pressure on the hee R1's Dietary Progree (Registered Dieticia Assessment on 11/ admission}. 483.75(I)(1) RES RECORDS-COMPILE The facility must mar resident in accordat standards and prac accurately document systematically orgat The clinical record of information to ident resident's assessm services provided; t preadmission scree and progress notes	like (R1's) wounds were over t't have been untreated for that ed 10/29/15 documents, "(R1) re ulcers related to {being} having}decreased mobility", ions of "avoid shearing (R1's) ing, transferring and turning, ic skin inspection weekly, as possible, keep lines clean, e, report any signs of skin els up cushion to relieve els while resident in bed." ess Notes documents, Z4 RD an) completed R1's initial 18/15 {27 days after LETE/ACCURATE/ACCESSIB aintain clinical records on each nce with accepted professional tices that are complete; nted; readily accessible; and nized. must contain sufficient ify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State;	F 3					
	This REQUIREMEN	NT is not met as evidenced						

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DEPART	FORM	APPROVED						
		& MEDICAID SERVICES	(X2) MUI	тірі			. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			· · · /	(X3) DATE SURVEY COMPLETED	
			-			(С	
		145347	B. WING			03/	03/10/2016	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GILMAN	HEALTHCARE CENT	ER	1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PRÉFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG				COMPLÉTION DATE	
					DEFICIENCY)			
F 514	Continued From pa							
1 514	by:	ige 12	F 514					
		eview and interview, the facility						
		ccurate pressure ulcer						
	documentation for one of three residents (R1) reviewed for complete clinical records.							
	Findings Include:							
	R1's undated face sheet documents R1 was							
	admitted to the facility on 10/22/15 with Diagnoses including Pressure Ulcer and Venous							
	Insufficiency.	g Fressure Olcer and verious						
	R1's Initial Nursing Assessment and Admission							
	Data dated 10/22/15 does not document R1 having any open areas but "2 cm (centimeter)							
	scar - white in color to right buttocks, multiple							
	scars to knee caps and scar to right elbow."							
	R1's Admission Body Observation dated 10/22/15							
	documents, "no pre	essure ulcers or sores."						
	0	es dated 10/22/15 by E7 LPN						
		Nurse) documents, "(R1)						
		via van from {hospital}(R1) (R1's) inner right ankle. Area						
		intimeters) by 1.5 cm. Wound						
		h slight discharge noted.						
	Wound Nurse Notif	IEU.						
		es dated 10/23/15 at 3:22 pm						
	by E6 RN (Register on heels."	red Nurse) documents, "scabs						
		documentation, in R1's						
		skin issues or concerns until d Nurse documents, "(Z3						
		here today to see (R1) and						
		age IIleft heel blisterright						

Facility ID: IL6003578

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		AND HUMAN SERVICES			FORM	03/14/2016 APPROVED 0938-0391		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	PLE CONSTRUCTION	(X3) DATE COM	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		145347	B. WING			C 10/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GILMAN	HEALTHCARE CENT	ER	1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 514	ball area {of foot} b The facility's ongoin was admitted on 10 ulcer to right inner a on the Admission B Nursing Assessmen R1 acquired stage heels and right first On 3/8/16 at 1:20 p Assurance) stated, information of when developed. (R1's) a stated, "(E7) doesn having four admiss charted in the wron At this same time, F admitted with the wron 10/29/15. (R1) was treatment ordered s that they developed On 3/9/15 at 10:20 admitted with very e ankle, bilateral heel "that's the facility's f The facility's Charti dated April 2008 do to the resident, or a	lister and right inner ankle" Ing Wound Log documents, R1 0-22-15 with mixed vascular ankle, which isn't documented body Observation or the Initial nt. This log also documents, II pressure ulcers to bilateral toe ball area on 11-2-16. If there is conflicting in (R1's) pressure ulcer's admitting nurse (E7 LPN) "t really remember and with ions that day, (E7) could have g chart"." E3 stated, "(R1) was not round to the right inner ankle, it did not have any open areas E3) contacted (Z3) on 10/28/15, as found for treatment orders." If was actually observed on seen by (Z3) on 11-2-15 and so that is why it is documented to n 11/2/15." am, Z3 stated R1 was extensive wounds to right Is and right ball of foot, and fault for not documenting." Ing and Documentation Policy bound to have in the resident's condition, shall be documented	F 51					

Facility ID: IL6003578

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		AND HUMAN SERVICES				FORM	03/14/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
145347		B. WING			C 03/10/2016		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GILMAN	HEALTHCARE CENT	ER	1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	observations, medi performed, etc., mu resident's clinical re procedures and tre	age 14 cations administered, services us be documented in the ecordsdocumentation of atments shall include care e assessment data and/or any	F	514			

Facility ID: IL6003578