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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #1661209/IL83833	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1	F 157		

by:
Based on record review and interview, the facility failed to notify the primary care physician and family of skin breakdown for one of three residents (R1) reviewed for notification of change in the sample of three.

Findings Include:

R1's undated face sheet lists the following Diagnoses: Pressure Ulcer and Venous Insufficiency.

R1's MDS (Minimum Data Set) dated 10-29-15 documents R1 is severely cognitively impaired.

On 3/8/16 at 8:50 am, Z1 (R1's POA (Power of Attorney)) stated, "(R1) was discharged from the facility on 1/22/16 and came to live with me. (R1) had an open sore on the foot. The facility never notified me of this. The only open area that I was aware that (R1) had was on the buttocks, they called and told me about that, but it was healed."

R1's Progress Notes dated 10/22/15 at 4:37 pm by E7 LPN (Licensed Practical Nurse) documents, "(R1) admitted to facility via van from {hospital}...(R1) has an area above (R1's) inner right ankle. Area measures 3 cm (centimeters) by 1.5 cm. Wound bed red in color with slight discharge noted. Wound Nurse Notified." There is no documentation of Z2, Primary Physician, or Z1 being notified of R1's wound or a treatment request.

R1's Progress Notes dated 10/23/15 at 3:22 pm by E6 RN (Registered Nurse) documents, "scabs on heels." There is no documentation of Z1 or Z2 being notified of these scabs.

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 R1's Progress Notes dated 11/2/15 by E3, Wound Nurse, documents, "(Z3 Wound Physician), here today to see (R1) and right heel blister stage II opened, opened left heel blister, and right ball of foot area and right inner ankle." There is no documentation of Z1 or Z2 being notified of these pressure ulcers. On 3/8/16 at 9:40 am, E7 stated, "I was the nurse who admitted (R1). (R1) had a sore on the right inner ankle. There was no treatment ordered. I let (E3) know about it, (E3) is the one that gets a hold of the doctor for treatment orders. I did not call (Z1) or (Z2) and update date them on the open area." On 3/9/16 at 11:15 am, E6 stated, "when I saw (R1), the day after admission, (R1) had what looked like black eschar {hard covering/scab} on both heels, approximately 1cm by 1 cm. I didn't actually measure the area because it wasn't open and we only measure when it is an open area. (R1) also had a 0.5 cm by 0.5 cm eschar area to the right big toes area. (R1) didn't have treatment orders but (E3) is the one that gets the treatment orders from (Z3 Wound Physician). I assumed (E3) was working on getting orders. Occasionally when (E3) is told of skin issues, (E3) will tell us to call the primary doctor but normally (E3) just contacts (Z3) for any orders. I did not call (Z1) or (Z2) to update them on (R1's) scabbed areas." Z3's Wound Assessment dated 11/2/15 for R1 documents Right Heel Pressure Ulcer Stage II - 6 cm by 4.5 cm, Left Heel Pressure Ulcer Stage II - 4 cm by 3 cm, Right Ankle - 2 cm by 1.5 cm, and Right first Metatarsal Stage II - 4 cm by 3 cm.	F 157		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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. 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." 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 record....documentation of procedures and treatments shall include care specific details and shall include at a minimum: notification of family, physician or other staff if indicated."	F 157		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP 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 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 4 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan for one of three resident (R1) reviewed for care plans in the sample of three. Findings Include: R1's Physician Order Report dated 10/22/15 - 3/8/16 documents R1 was admitted to the facility, from the hospital on 10-22-15 with a Diagnosis of Dehydration and a diet order of mechanical soft foods with nectar thick liquids. R1's Dehydration Risk Assessment dated 10/23/15 and 1/19/16 documents "high risk for dehydration." R1's Care plan dated 11/5/15 does not document R1 being at risk for Dehydration, having a Diagnosis of Dehydration, or the signs/symptoms staff need to monitor. On 3/8/16 at 11:45 am, E11 RN/CP Coordinator (Registered Nurse/Care Plan Coordinator) was unable to answer questions regarding R1's dehydration diagnosis and lack of care plan. E11 stated, "I wasn't employed at the facility when (R1) was admitted but the fact that (R1) had just been released from the hospital with an active diagnosis of dehydration, (R1) should have been	F 279		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 5 care planned as such so staff would know that (R1) was at heightened risk and needed monitoring. The fact that (R1) was on thickened liquids, put (R1) at risk, even without a diagnosis." The facility's Hydration- Clinical Protocol dated October 2010 documents, "the physician and staff will identify individuals with a significant risk for subsequent fluid and electrolyte imbalance; for example, those with prolonged vomiting, diarrhea, fever, or who are taking diuretics and/or who are not eating and drinking well." The facility's Care Plans - Comprehensive Policy dated November 2010 documents, "an individual comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident...comprehensive care plans are designed to incorporate identified problem areas and risk factors associated with identified problems."	F 279		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 6	F 314		

by:
Based on record review and interview, the facility failed to follow their policy on wound management, and failed to follow the care plan to prevent further deterioration of existing wounds for one of three residents (R1) reviewed for pressure ulcers. This failure resulted in R1 not receiving pressure ulcer treatments to wounds for 11 days and R1's right heel pressure ulcers increasing in size from 1 cm (centimeter) by 1 cm to 6 cm by 4.5 cm.

Findings Include:

The facility's Pressure Ulcer Treatment Policy dated October 2010 documents, "The purpose of this procedure is to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers...the pressure ulcer treatment program should focus on the following strategies: assessing the resident and the pressure ulcer, managing tissue loads, and pressure ulcer care....notify physician..protect {the wound}, manage drainage, {provide} treatment per physician order."

The facility's Pressure Ulcer Risk Assessment Policy dated October 2010 documents, "The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers...the most common site of a pressure ulcer is where the bone is near the surface of the body including the back of the hear around the ears, elbows, shoulder blades, backbone, hips, knees, heels, ankles, and toes."

R1's undated facesheet documents the following Diagnoses: Pressure Ulcer and Venous

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 7 Insufficiency. R1's MDS (Minimum Data Set) dated 10-29-15 documents R1 is severely cognitively impaired, requires extensive assist of 2 assist for bed mobility and transfers, and is non-ambulatory. R1's Progress Notes dated 10/22/15 at 4:37 pm by E7 LPN (Licensed Practical Nurse) documents, "(R1) admitted to facility via van from {hospital}...(R1) has an area above (R1's) inner right ankle. Area measures 3 cm (centimeters) by 1.5 cm. Wound bed red in color with slight discharge noted. Wound Nurse Notified." There is no documentation of (Z2 Primary Physician) being notified of R1's open wound or a treatment request. R1's Progress Notes dated 10/23/15 at 3:22 pm by E6 RN (Registered Nurse) documents, "scabs on heels." R1's Skin Risk Assessment dated 10/23/15 documents R1 is at moderate risk for skin breakdown. R1's clinical record documents the following order received on 10/28/15{6 days after ankle wound is found}: "cleanse area to right lower leg, inner ankle area, then apply Betadine, cover with Alginate and then bordered Hydrocolloid dressing and change two times a week and PRN (as needed)." There are no orders documented for the scabbed area's on R1's heels. R1's clinical record documents the following order dated November 2015 {11 days after R1 was admitted with areas present}: "cleanse area to right and left heel and ball of right toe with Betadine,cover with Nystantin Powder cover with Alginate then	F 314		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 8 bordered Hydrocolloid dressing QOD (every other day) and PRN." 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." On 3/8/16 at 9:40 am, E7 stated, "I was the nurse who admitted (R1). (R1) had a sore on the right inner ankle. There was no treatment ordered. I did not see any other area of concern. I let (E3, Wound Nurse) know about it, (E3) is the one that gets a hold of the doctor for treatment orders. The only pressure ulcer intervention I initiated upon admission was a heels up for (R1) to keep (R1's) heels off the bed while lying down." On 3/9/16 at 11:15 am, E6 stated, "when I saw (R1), the day after admission, (R1) had what looked like black eschar {hard covering/scab} on both heels, approximately 1cm by 1 cm. I didn't actually measure the area because it wasn't open and we only measure when it is an open area. (R1) also had a 0.5 cm by 0.5 cm eschar area to the right big toes area. These areas were really hard to see since (R1) is dark skinned. (R1) didn't have treatment orders but (E3) is the one that gets the treatment orders from (Z3 Wound Physician). I assumed (E3) was working on getting orders." R1's Progress Notes do not document any skin concerns or pressure ulcers from 10/23/15 until 11/2/15 by E3. E3 documents, "(Z3) here today to see (R1) and right heel blister, stage II, was opened per (Z3) and then cleansed and dressing applied. Then (Z3) opened left heel blister and cleansed and new dressing applied, the right ball	F 314		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 9	F 314		

area blister opened and cleansed and dressing applied. Area to right inner ankle cleansed and dressing applied. Wound base 100% granulation and color consistency red and adherent wound edges attached and well defined and moderate amount of serous drainage noted. (R1) tolerated and also wants foam boots and heels up while in bed and {offloading} boots on while in wheelchair. Arterial Doppler to bilateral lower legs."

Z3's Wound Assessment dated 11/2/15 for R1 documents Right Heel Pressure Ulcer Stage II - 6 cm by 4.5 cm, Left Heel Pressure Ulcer Stage II - 4 cm by 3 cm, Right Ankle - 2 cm by 1.5 cm, and Right first Metatarsal Stage II - 4 cm by 3 cm.

On 3/9/16 at 8:50 am, E3 stated, "I was told of (R1) having an open area to the right inner ankle on 10/28/15, that is when I called (Z3) and got the treatment order, come to find out staff had noticed it when (R1) was admitted. I don't know why they didn't say anything sooner to me. I was then notified of unstageable blood blisters on (R1's) heels and ball of foot on 10/29/15 and same thing, the staff knew about those areas also but didn't say anything sooner. I texted a picture of (R1's) foot to (Z3) but (Z3) didn't respond. (R1) was seen by (Z3) on 11/2/15 and a treatment was ordered at that time. No treatment was being done to (R1's) heels and ball of foot until then {11 days}. I don't see the residents unless I'm informed they have skin issues, I need to be informed as soon as the problem is observed."

On 3/9/16 at 9:15 am, E4 stated, "upon admission, the nursing staff need to implement precautionary skin interventions, and people need to report skin issues immediately so the nurse can update the physician and the problem can be

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 10	F 314		

addressed...I don't know why staff didn't follow up when (Z3) didn't return call. We {facility} have standing orders for wound care, they should have at least activated those orders."

On 3/9/16 at 10:20 am, Z3 stated, "(E3) called me on 10/28/15 about (R1's) ankle wound and I gave recommendations and the treatment was started. I saw (R1) on 11/2/15 and (R1) had extreme ulcers all over, I documented everything on my Wound Assessment, they were a mixture between pressure and vascular, all the wounds were present on admission and bad on them {facility} for not calling me until they were so extreme. (R1's) wounds were so extreme when I first saw them, I wasn't sure if (R1) would survive, but (R1) did and with proper treatment, the majority of the wounds actually healed." Z3 was told E3 stated E3 had sent a picture text on 10/29/15 to Z3 but didn't get a response. Z3 stated, "If I didn't respond, they still have a primary responsibility to treat the resident, they could have called (Z2), I'm only at the facility once a week to give recommendations." Z3 also stated, "My expectation is that the facility should do a skin swoop upon admission and implement appropriate prevention interventions...someone like (R1) who is emaciated, malnourished, has decreased mobility and poor nutrition is high risk for breakdown if the Skin Risk Assessment is done correctly, that would put the resident at high risk and they should have an Alternating Air Mattress, an immediate nutritional evaluation, heel booties and offloading started for prevention."

On 3/9/16 at 10:30 am, E3 stated, "(Z3) was really upset when (Z3) first saw the condition of (R1's) wounds and actually told (E10 Former

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 11 DON) that (Z3) felt like (R1's) wounds were over looked and shouldn't have been untreated for that long." R1's Care Plan dated 10/29/15 documents, "(R1) is at risk for pressure ulcers related to {being} under weight and {having}decreased mobility", with initial interventions of "avoid shearing (R1's) skin during positioning, transferring and turning, conduct a systematic skin inspection weekly, keep clean and dry as possible, keep lines clean, dry and wrinkle free, report any signs of skin breakdown, use heels up cushion to relieve pressure on the heels while resident in bed." R1's Dietary Progress Notes documents, Z4 RD (Registered Dietician) completed R1's initial Assessment on 11/18/15 {27 days after admission}.	F 314		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 12	F 514		

by:
Based on record review and interview, the facility failed to maintain accurate 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.

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 pressure ulcers or sores."

R1's Progress Notes dated 10/22/15 by E7 LPN (Licensed Practical Nurse) documents, "(R1) admitted to facility via van from {hospital}...(R1) has an area above (R1's) inner right ankle. Area measures 3 cm (centimeters) by 1.5 cm. Wound bed red in color with slight discharge noted. Wound Nurse Notified."

R1's Progress Notes dated 10/23/15 at 3:22 pm by E6 RN (Registered Nurse) documents, "scabs on heels."

There was no other documentation, in R1's Progress Notes, of skin issues or concerns until 11/2/15. E3 Wound Nurse documents, "(Z3 Wound Physician) here today to see (R1) and right heel blister, stage II...left heel blister...right

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 13 ball area {of foot} blister and right inner ankle..." The facility's ongoing Wound Log documents, R1 was admitted on 10-22-15 with mixed vascular ulcer to right inner ankle, which isn't documented on the Admission Body Observation or the Initial Nursing Assessment. This log also documents, R1 acquired stage II pressure ulcers to bilateral heels and right first toe ball area on 11-2-16. On 3/8/16 at 1:20 pm, E5 LPN/QA (Quality Assurance) stated, "there is conflicting information of when (R1's) pressure ulcer's developed. (R1's) admitting nurse (E7 LPN) stated, "(E7) doesn't really remember and with having four admissions that day, (E7) could have charted in the wrong chart"." At this same time, E3 stated, "(R1) was not admitted with the wound to the right inner ankle, it was acquired. (R1) did not have any open areas upon admission. (E3) contacted (Z3) on 10/28/15, when the wound was found for treatment orders." On 3/9/16 at 8:50 am, E3 stated, "(R1's) heels and ball of right foot was actually observed on 10/29/15. (R1) was seen by (Z3) on 11-2-15 and treatment ordered so that is why it is documented that they developed on 11/2/15." On 3/9/15 at 10:20 am, Z3 stated R1 was admitted with very extensive wounds to right ankle, bilateral heels and right ball of foot, and "that's the facility's fault for not documenting." The facility's Charting and Documentation Policy dated April 2008 documents, "all service provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record....all	F 514		

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 _____	C 03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 14 observations, medications administered, services performed, etc., must be documented in the resident's clinical records...documentation of procedures and treatments shall include care specific details...the assessment data and/or any unusual findings.	F 514		