STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145347	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GILMAN HEALTHCARE CENTER	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)
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify a representative of the Office of the State Long-Term Care Ombudsman of an involuntary discharge for one of three residents (R1) reviewed for involuntary discharge in the sample of 21. Findings include: R1's Census dated 8/11/20 documents R1 admitted to the facility on [DATE] and was sent to the hospital on [DATE]. This Census documents R1 did not return and was discharged from the facility on 3/24/20. R1's Notice of Involuntary Transfer or Discharge and Opportunity for Hearing for Nursing Home Residents dated 3/20/20 documents R1's transfer was an emergency transfer or discharge due to the safety of individuals in this facility is endangered. On 8/6/20 at 10:13 AM V1 Administrator stated R1 was involuntarily discharged from the facility on 3/20/20. On 8/10/20 at 10:10 AM V30 Ombudsman stated the Office of the State Long-Term Care Ombudsman had not received a notice of R1's involuntary discharge from the facility. On 8/11/20 at 12:00 PM V1 stated V1 was unable to provide documentation that the Office of the State Long-Term Care Ombudsman was notified of R1's involuntary discharge from the facility on 3/20/20. The facility's Transfer or Discharge Notice policy revised December 2012 does not document the facility will notify the Office of the State Long-Term Care Ombudsman of resident transfers and discharges.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide showers as scheduled for three of three residents (R2, R6, R13) reviewed for activities of daily living in the sample list of 21. Findings include: 1. R2's Minimum Data Set ((MDS) dated [DATE] documents R2 is cognitively intact and is totally dependent upon two staff for bathing assistance. R2's Care Plan revised on 6/30/20 documents R2 has a self care deficit and needs assistance with activies of daily living. This Care Plan documents an intervention dated 5/20/19 Showers twice weekly as tolerated or bed bath daily and PRN (As Needed.) Total assist of 2 staff. R2's Grievance/Complaint Investigation Report Form dated 4/17/20 documents R2 was wanting to verify R2's shower day since R2's room change. This form documents R2's shower days are scheduled on Tuesday and Friday midnights, R2 received a shower on 4/17/20 and R2's shower schedule was shared with R2. R2's Grievance/Complaint Investigation Report Form dated 6/24/20 documents R2 has not been getting R2's showers since R2's shower schedule was changed. This form documents the corrective action will be to offer R2 showers two times per week and signed by V2 Director of Nursing. R2's shower sheets were reviewed. There is no documentation that R2 received showers between 3/10-3/17, 3/24-3/29, 4/1-4/16, 4/18-4/27, 6/5-6/15, 7/1-7/9, and 7/11-7/21. On 8/10/20 at 3:40 PM V2 confirmed shower documentation was missing for R2, and R2 did not receive showers per R2's plan of care. V2 stated residents should be offered showers two times per week. 2. R6's Face Sheet documents R6 admitted to the facility on [DATE] and discharged on [DATE]. R6's MDS dated [DATE] documents R6 has moderate cognitive impairment and uses extensive assistance of two staff for bathing. R6's Care Plan revised on 5/4/20 documents R6 has a self care deficit with activities of daily living with an intervention that R6 is totally dependent upon two staff for showers. R6's Grievance Form dated 3/25/20 documents V17 (R6's Family Member) had concerns that R6 was not receiving R6's showers. This form documents Findings: educated staff on completing all showers and to notify nurse if any resident refuses a shower. R6's shower sheets document R6 received showers on 3/8, 3/12, 3/19, 3/25, 4/2. There is no documentation that R6 received showers 3/1-3/7, 3/13-3/18, 3/20-3/24, 3/26-4/1, and 4/21-4/26/20. On 8/6/20 at 11:40 AM V17 stated in March there were days R6 did not appear as if R6 had been receiving R6's showers. V17 described R6 as being unclean and and R6 had an odor. On 8/10/20 at 3:40 PM V2 Director of Nursing confirmed shower documentation was missing for R6, and R6 had not received showers two times per week. V2 stated residents should be offered showers two times per week. 3. R13's Face Sheet dated 8/10/20 documents R13 admitted to the facility on [DATE]. R13's MDS dated [DATE] documents R13 has cognitive impairment and uses extensive assistance of two staff for bathing. R13's Care Plan revised on 6/30/20 documents R13 has a self care deficit and requires assistance with activities of daily living. This Care Plan documents an intervention dated 3/20/20 for R13 to receive showers twice weekly. The facility's shower schedule documents R13's scheduled shower days are Wednesdays and Saturdays. R13's shower sheets document R13 received showers on 3/21, 7/1, 7/4, 7/8, 7/11, 7/18, and 7/25/20. There is no documentation that R13 received scheduled showers on 3/25, 3/28, 7/15, 7/22, 7/29, 8/1, and 8/5/20. On 8/10/20 at 3:40 PM V2 Director of Nursing confirmed shower documentation was missing for R13, and R13 did not receive showers per R13's plan of care. V2 stated residents should be offered showers two times per week. The facility's Resident Shower or Bed Bath policy dated August 2020 documents showers are to be given to residents at least twice per week and as needed.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to administer medications timely and as ordered, obtain physician's orders prior to administering insulin, and notify a physician of blood glucose levels as ordered for four of 11 residents (R1, R2, R7, R8) reviewed for medication administration in the sample of 21. Findings include: 1. R8's Face Sheet dated 8/10/20 documents R8 has [DIAGNOSES REDACTED]. R8's Physician Orders Summary dated 8/12/20 documents an order for [REDACTED]. dated 7/29/20 documents to obtain R8's blood glucose level before meals and at bedtime. This order documents to notify the physician (V31) if R8's blood sugars are below 70 or greater than 300. R8's Medication Administration Record [REDACTED]. This MAR indicated [REDACTED]. This MAR indicated [REDACTED]. This MAR indicated [REDACTED]. R8's blood sugar was 238 on 8/6 at 8:00 PM and R8's Humalog was not administered. R8's blood sugar was 433 on 8/7 at 8:00 PM and and V4 Licensed Practical Nurse (LPN) administered 1 unit of Humalog (not 5 units as ordered.) There is no documentation in R8's medical record that R8's Physician V31 was notified of R8's blood sugars below 70 and above 300. There is no documentation that V31 was notified or orders were obtained to hold R8's Humalog on 8/3, 8/6, and 8/7/20 or to administer a lower dose than ordered on 8/7. On 8/10/20 at 5:18 PM V4 LPN confirmed V4 administered Humalog 1 unit to R8 on 8/7 at 8:00 PM. V4 stated V4 did not notify V31 to obtain orders to administer a lower amount of Humalog than ordered. V4 stated R8 is a brittle diabetic and R8's blood sugars fluctuate. On 8/10/20 at 3:40 PM V2 Director of Nursing confirmed V31 was not notified of R8's blood sugars on 8/2, 8/3, 8/4, 8/6, 8/7, and 8/8 and there was no documentation that V31 was notified or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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F 0684

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

(continued... from page 1)
orders were obtained to hold R8's Humalog on 8/3, 8/6, and 8/7/20 or to administer a lower dose than ordered on 8/7. V2 stated V2 would expect the nurses to follow physician orders. On 8/11/20 at 3:00 PM V31 stated V31 was not aware that R8's blood sugars had been ranging from 40-60's and V31 would have expected to have been notified. V31 stated sometimes the nurses choose to give R8 less insulin than ordered to avoid causing R8's blood sugar to drop. 2. R7's Face Sheet dated 8/10/20 documents R7 has a [DIAGNOSES REDACTED]. R7's Physician Order summary dated 8/11/20 documents orders for [MEDICATION NAME] (Insulin) 40 units daily at 8:00 PM, [MEDICATION NAME] R (Insulin) 10 units subcutaneous twice daily at
11:30 AM and 5:00 PM if blood sugar is greater than 200 and to obtain R7's blood sugar every 4 hours. There is no order for parameters for R7's blood sugar results to be reported to V32 Physician. R7's MAR indicated [REDACTED]. This MAR indicated [REDACTED]. This MAR indicated [REDACTED]. R7's MAR indicated [REDACTED]. This MAR indicated [REDACTED]. 53 on 7/27. R7's
Nursing Note dated 8/5/20 at 11:58 PM documents R7's blood sugar was 325 and R7 requested [MEDICATION NAME] R 10 units be
administered. There's no documentation that R7's Physician V32 was notified to give orders to administer [MEDICATION NAME] R at 11:58 PM on 8/5/20 or that V32 was notified of R7's low blood sugars. On 8/10/20 at 9:53 AM V26 LPN stated R7's blood sugars run low at times and R7 does not have any parameters for when V32 should be notified of R7's blood sugar levels. V26 stated R7 requests the amount of insulin that R7 wants administered. V26 stated V26 did not notify V32 to obtain orders to administer [MEDICATION NAME] R on 8/5/20. V26 stated (V32) understands how (R7) is. On 8/10/20 at 4:45 PM V4 LPN stated R7
gets scheduled insulin, but R7 likes to request a lower dosage be given especially the long acting insulin. V4 stated the staff do not notify V32, since V32 is already aware that R7 requests the amount of insulin R7 receives. On 8/10/20 at 3:40 PM V2 Director of Nursing confirmed R7 does not have orders for parameters for R7's blood sugar results to be reported to V32 Physician. V2 stated any blood sugar below 60 should be reported to the physician. V2 stated V2 would expect the nurses to follow physician orders and V32 should have been notified to receive an order to administer [MEDICATION NAME] R to R7 on 8/5/20. 3. R1's Face Sheet dated 3/16/20 documents R1 has a [DIAGNOSES REDACTED]. R1's Physician's Order Report dated 2/16-3/16/20 documents orders to obtain R1's blood sugars before meals and at bedtime and to notify V14 Physician if the blood sugar is less than 70 or greater than 300. This report documents orders for Humalog (Insulin) 12 units subcutaneous at three times daily at 8:00 AM, 12:00 PM, and 6:00 PM; [MEDICATION NAME] (Antihypertensive) Extended Release 25 mg (milligrams) daily at 8:00 AM, [MEDICATION NAME] (Antipsychotic) 1 mg daily at 8:00 AM, [MEDICATION NAME] (Antidepressant)
75 mg daily at 8:00 AM, and Memantine (Medication for [MEDICAL CONDITION]) 10 mg twice daily at 8:00 AM and 8:00 PM. R1's
MAR indicated [REDACTED]. R1's blood sugar at 11:00 AM was 367 on 2/10, 362 on 2/13, 384 on 2/15, 364 on 2/16, and 364 on 2/17. R1's blood sugar at 4:00 PM was 400 on 2/4, 358 on 2/7, 347 on 2/8, 376 on 2/10, 399 on 2/13, 324 on 2/14, 356 on 2/15, 366 on 2/16, 358 on 2/18 and 2/20, 368 on 2/23, 357 on 2/25 and 390 on 2/26/20. Humalog 12 units, [MEDICATION NAME] 150 mg, and [MEDICATION NAME] 1 mg scheduled at 8:00 AM were administered at 10:33 AM on 2/5, 10:01 AM on 2/7, 10:20 AM on
2/8, 11:15 AM on 2/14, 11:14 AM on 2/22, 10:45 AM on 2/23, 10:39 AM on 2/24, and 12:04 PM on 2/27/20. Humalog 12 units at 12:00 PM was administered at 2:03 PM on 2/3, 1:59 PM on 2/22, 2:17 PM on 2/23, and 2:00 PM on 2/24. Humalog 12 units and Memantine 5 mg at 6:00 PM was administered at 9:12 PM on 2/12 and 9:21 PM on 2/13. This MAR indicated [REDACTED]. R1's MAR
indicated [REDACTED]. R1's blood sugar at 11:00 AM was 366 on 3/13, 310 on 3/14, at 4:00 PM was 353 on 3/13, 330 on 3/15, and at 8:00 PM was 346 on 3/12, and 353 on 3/13. Humalog 12 units scheduled for 6:00 PM was administered at 9:11 PM on 3/9 and at 8:45 PM on 3/13/20. Humalog 12 units scheduled for 8:00 AM was administered at 12:24 PM on 3/10, 11:25 AM on 3/11, 11:41 AM on 3/12, 12:15 PM on 3/13, 10:06 AM on 3/14/20. [MEDICATION NAME] Extended Release 25 mg was administered on 3/10
at 12:55 PM, 3/11 at 11:25 AM, 3/12 at 11:41 AM, 3/13 at 12:15 PM, 3/14 at 10:06 AM, 3/15 at 11:02 AM, and 3/16 at 10:11 AM. [MEDICATION NAME] 75 mg and [MEDICATION NAME] 1 mg scheduled at 8:00 AM were administered on 3/11 at 11:25 AM, 3/12 at
11:41 AM, 3/13 at 12:13 PM. This MAR indicated [REDACTED]. There is no documentation in R1's medical record that V14 Physician was notified of R1's blood sugars that were greater than 300. On 8/6/20 at 8:58 AM V29 LPN stated sometimes medications are administered late and are documented as administered or charted late. V29 stated in March the nurses were being utilized to pass breakfast trays to the residents since we were short on Certified Nursing Assistants. V29 stated the nurses would have to stop their medication pass and resume once breakfast was served. On 8/11/20 at 11:15 AM V14 Physician stated ideally the nursing staff should have informed me of R1's elevated blood sugars. On 8/10/20 at 3:40 PM V2 Director of Nursing stated V2 expects the nurses to follow physician's orders. V2 stated medications are to be administered within one hour before or after the ordered time and documented at the time of administration. V2 stated V2 did not know why the medications were being documented as administered or charted late. V2 confirmed there was no documentation that V14 was notified of R1's blood sugars. 4. R2's Face Sheet dated 3/16/20 documents R2 has a [DIAGNOSES REDACTED]. R2's Physician's Order Report dated 2/16-3/16/20 documents orders for [MEDICATION NAME] (Antiarrhythmic) 200 mg daily at 8:00 AM, Eliquis (Anticoagulant) 2.5 mg BID (twice daily) at 8:00 AM and 8:00 PM, Humalog 10 units subcutaneous before meals at 7:00 AM, 11:30 AM, 5:30 PM, [MEDICATION NAME] (Antihypertensive) 50 mg BID at 8:00 AM and 6:00 PM. R2's MAR indicated [REDACTED].
Eliquis was administered at 11:58 AM on 2/5, 11:39 AM on 2/7, 10:08 AM on 2/8, 10:02 PM on 2/10, 11:12 AM on 2/14, 10:38 PM on 2/17, 11:15 AM on 2/22, 10:46 PM on 2/23, 1:54 PM on 2/24, and 12:02 PM on 2/27. Humalog scheduled at 7:00 AM was administered at 9:33 AM on 2/4, 11:58 AM on 2/5, 9:20 AM 2/6, 11:39 AM on 2/7, 10:08 AM on 2/8, 9:18 AM on 2/9, 12:07 PM on 2/10, 9:43 AM on 2/11, 9:37 AM on 2/12, 11:12 AM on 2/14, 9:28 AM on 2/15, 9:27 AM on 2/16, 9:12 AM on 2/17, 10:38 AM on 2/18, 9:35 AM on 2/20, 9:30 AM on 2/21, 11:16 AM on 2/22, 10:46 AM on 2/23, 12:25 PM on 2/25, 9:41 AM on 2/26, and 9:55 AM on 2/29. Humalog scheduled at 11:00 AM was administered at 1:57 PM on 2/3, 1:03 PM on 2/10, 1:43 PM on 2/13, 1:14 PM on 2/14, 1:15 PM on 2/17, 1:07 PM on 2/18, 1:10 PM on 2/20, 2:02 PM on 2/22, 2:18 PM on 2/23, 1:55 PM on 2/26, 2:23 PM on 2/27, and 1:21 PM on 2/29. Humalog scheduled at 5:00 PM was administered at 7:50 PM on 2/1, 7:43 PM on 2/2, 8:22 PM on 2/13, 10:38 PM on 2/17, 7:42 PM on 2/24, and 7:51 PM on 2/25. [MEDICATION NAME] was administered at 11:58 AM on 2/5, 11:39
AM on 2/7, 10:47 AM on 2/11, 11:12 AM on 2/14, 10:38 PM on 2/17, 11:15 AM on 2/22, 10:46 AM on 2/23, 1:54 PM on 2/24, and 12:02 PM on 2/29. This MAR indicated [REDACTED]. R2's MAR indicated [REDACTED]. Humalog scheduled at 7:00 AM was given at
9:55 AM on 3/2, 9:21 AM on 3/3, 10:22 AM on 3/4, 9:40 AM on 3/5, 9:16 AM on 3/10, 11:28 AM on 3/11, 11:37 AM on 3/12, 9:42 AM on 3/13, 10:03 AM on 3/14, 10:17 AM on 3/15, 9:38 AM on 3/16, 10:17 AM on 3/17, 12:37 PM on 3/18, 10:27 AM on 3/20, 12:03 PM on 3/21, 10:05 AM on 3/22, 10:41 AM on 3/25, 9:31 AM on 3/26, 11:19 AM on 3/2710:26 AM on 3/29, and 11:53 AM on 3/31. Humalog scheduled at 11:00 AM was given at 1:08 PM on 3/4, 1:05 PM on 3/7, 1:27 PM on 3/14, 1:12 PM on 3/16, 2:03 PM on 3/18, 2:01 PM on 3/20, 1:24 PM on 3/21, 1:34 PM on 3/26, 1:41 PM on 3/27, and 1:09 PM on 3/30. Humalog scheduled at 5:00 PM was given at 9:45 PM on 3/58:17 PM on 3/12, 8:41 PM on 3/13, 8:50 PM 3/14, 7:19 PM on 3/24, 7:11 PM on 3/29. [MEDICATION NAME] scheduled at 6:00 PM was given at 9:45 PM, on 3/5, 9:21 PM on 3/9, 9:41 PM on 3/10, 8:24 PM on 3/13, 8:50 PM on 3/14, 8:43 PM on 3/20, and 9:26 PM on 3/26. On 8/6/20 at 8:58 AM V29 LPN stated sometimes medications are administered late and
are documented as administered or charted late. V29 stated in March the nurses were being utilized to pass breakfast trays to the residents since we were short on Certified Nursing Assistants. V29 stated the nurses would have to stop their medication pass and resume once breakfast was served. On 8/10/20 at 3:40 PM V2 Director of Nursing stated V2 expects the nurses to follow physician's orders. V2 stated medications are to be administered within one hour before or after the ordered time and documented at the time of administration. V2 stated V2 did not know why the medications were being documented as administered or charted late. V2 confirmed there was no documentation that V14 was notified of R1's blood sugars. The facility's Diabetes-Clinical Protocol revised October 2010 documents 4. The physician will order desired parameters for monitoring and reporting information related to diabetes or blood sugar management. a. The staff will incorporate such parameters into the Medication Administration Record [REDACTED]. This policy documents 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 5. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. This policy documents the individual administering the medication will record the date and time the medication was administered in the resident's medical record.

F 0759

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.
NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY
Based on observation, interview, and record review the facility failed to administer medications according to physician orders [REDACTED]. The facility had two medication errors out of 28 opportunities resulting in an 8 % medication error rate. Findings include: 1. R8's Physician order [REDACTED]. R8's noon meal tray was located beside R8's bed, and R8 had consumed all of R8's meal. R8's blood sugar was 246. V20 then administered Humalog one unit subcutaneous to R8. On 8/10/20

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) at 12:46 PM V20 confirmed R8's Humalog is ordered to be given before meals and R8 had already consumed R8's noon meal. V20 stated V20 was not aware that R8's Humalog was ordered to be given before meals since this was V20's first time assigned to R8. R8's 14 Day Administration History Report dated 7/29-8/11/20 documents on 8/10/20 V20 administered R8's 11:00 AM scheduled dose of Humalog at 2:00 PM with the documented reason as charted late. On 8/10/20 at 3:40 PM V2 Director of Nursing stated medications are to be administered within one hour before or after the scheduled time to be given. V2 stated V2 would expect the nurses to follow physician's orders [REDACTED]. R18's Physician order [REDACTED]. V4 did not obtain R18's pulse prior to administration. R18's 14 Day Administration Report dated 7/29-8/11/20 documents R18 received [MEDICATION NAME] twice daily, but does not document R18's pulse prior to administration. R18's 14 Day Administration Report dated 7/29-8/11/20 documents R18's vitals are obtained every shift. This report documents R18's pulse on 7:00 AM - 3:00 PM shift was 49 on 7/31, 52 on 8/2, 56 on 8/4, 55 on 8/5, 49 on 8/6, and 59 on 8/8/20. This report documents R18's pulse on the 3:00 PM -11:00 PM shift was 56 on 7/30, 50 on 7/31, 57 on 8/2, 57 on 8/4, 53 on 8/6, 56 on 8/7, and 58 on 8/10. This report does not document the exact time that R18's pulse is obtained. On 8/11/20 at 11:54 AM V2 Director of Nursing stated R18's pulse should be obtained prior to administering R18's [MEDICATION NAME]. V2 stated R18's pulse has been obtained once per shift and confirmed that the documentation does not specify the time that R18's pulse is obtained. The facility's Administering Medications policy revised December 2012 documents Medications shall be administered in a safe and timely manner, and as prescribed. This policy documents the date and time the medication is administered will be recorded in the resident's medical record. The facility's Medication Errors policy dated October 2015 documents A medication error is when an event or situation lead to inappropriate medication use related to professional practice, health care products, procedures and systems, including prescribing; order communication; product labeling; packaging; dispensing; distribution; administration; education; monitoring, and use.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility staff failed to discard or decontaminate personal protective equipment (PPE) eye protection after providing direct care for residents in quarantine/isolation for Covid-19 (Coronavirus Disease 2019) precautions before providing care to other residents and failed to disinfect an inhaler spacer after use. Housekeepers failed to wear eye protection when cleaning in resident rooms with residents present. In addition the facility failed to initiate isolation precautions to prevent potential spread of infection for a person under investigation (PUI) for Covid-19 (R14). The facility is currently experiencing an outbreak of [DIAGNOSES REDACTED] CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2) among it's residents and employees. This has the potential to affect eight residents (R1, R2, R7, R14, R15, R16, R17, and R19) of 12 reviewed for infection control in the sample list of 21 residents. The findings include: 1. On 8/6/2020 at 10:30 am a Calling Post Call letter dated 8/5/2020 was posted on the facility outside entrance door that stated the facility had identified two new residents and two more staff with symptoms of Covid-19. The notice stated The cumulative total for residents who have tested positive still remains at 45 and cumulative total for employees still remains at 29. On 8/10/2020 at 11:00 am the Calling Post Call letter dated 8/7/2020 on the front door stated the cumulative numbers were at 46 residents and 29 staff and one positive resident had been sent to the hospital. On 8/10/20 at 4:29 PM V4 Licensed Practical Nurse (LPN) applied a surgical mask, isolation gown, and gloves to enter R15's room to administer R15's [MEDICATION NAME] inhaler. V4 was already wearing PPE eye protection. There was a sign on R15's door documenting R15 was on droplet and contact isolation. V4 administered R15's inhaler with the use of a spacer. V4 removed V4's mask, gown, and gloves. V4 did not remove or disinfect V4's eye protection upon leaving R15's room. V4 returned to the medication cart and without disinfecting R15's spacer (that came into direct contact with R15's mouth), placed the spacer into the top drawer of the medication cart with other resident medications. V4 stated R15 is on isolation due to R15's room mate (R21) tested positive for Covid-19, and R15's test results are pending. V4 confirmed V4 did not disinfect R15's inhaler spacer prior to placing it in the top drawer of the medication cart. V4 stated there was no reason the spacer would need to be disinfected. V4 then obtained a blood glucose meter, applied gloves, mask, and isolation gown and entered R7's room at 4:45 PM. V4 was wearing the same eye protection worn in R15's room. There was a sign posted on R7's room that documented R7 was on contact and droplet isolation precautions. V4 obtained R7's blood glucose level and administered R7's [MEDICATION NAME] R insulin. V4 removed V4's gloves, mask, and gown. V4 did not remove or disinfect V4's eye protection upon leaving R7's room. V4 returned to the medication cart and obtained R16's medications [MEDICATION NAME], and Biofreeze. V4 wearing a surgical mask and the same eye protection worn in R15's and R7's room, entered R16's room at 5:00 PM and administered R16's medications. There was no signage posted on R16's door regarding isolation precautions. On 8/10/20 at 5:18 PM V4 confirmed V4 used the same pair of eye protection into R15's, R7's and R16's room and V4 had not disinfected the eye protection between each room. V4 stated the eye protection should be changed or disinfected with a bleach wipe. On 8/10/20 at 5:23 PM V2 Director of Nursing stated eye protection is kept in the isolation carts located outside of each resident room that is on isolation. V2 stated staff should either discard the eye protection into the bin for decontamination upon leaving the resident isolation room, or disinfect the eye protection upon leaving the room prior to going into another resident room. On 8/10/20 at 9:20 AM V2 stated inhaler spacers should be disinfected after being used by a resident on isolation. V2 confirmed V4 should have disinfected R15's inhaler spacer prior to placing the spacer into the top drawer of the medication cart. V2 stated the medication cart will need to be disinfected. V2 stated the facility does not have a policy on the reuse of eye protection. V2 stated R7 and R15 are on isolation and have pending [DIAGNOSES REDACTED] CoV-2 tests. V2 stated R7's prior room mate (R5) and R15's prior room mate (R21) had tested positive for [DIAGNOSES REDACTED] CoV-2. On 8/12/20 at 12:18 PM V2 provided a list of resident medications located in the top drawer of the medication cart where R15's inhaler and spacer are stored. This list documents R7's Artificial Tears eye drops and Incruse Ellipta (inhaler), and R19's Refresh Tears eye drops, [MEDICATION NAME] (inhaler), [MEDICATION NAME] (inhaler), [MEDICATION NAME] (inhaler), and Fosomax were located in the top drawer of the medication cart. R15's Census dated 8/12/20 and R21's Census dated 8/12/20 document that R15 and R21 shared a room from 7/10-7/28/20. R7's Census dated 8/12/20 and R5's Census dated 8/11/20 document that R5 and R7 shared a room from 7/7-7/28/20. R21's laboratory report dated 7/28/20 documents [DIAGNOSES REDACTED] CoV-2 detected. R5's Laboratory report dated 7/28/20 documents [DIAGNOSES REDACTED] CoV-2 detected. R16's laboratory report dated 8/1/20 documents [DIAGNOSES REDACTED] CoV-2 was not detected. R15's Nursing Note dated 8/6/20 at 2:24 AM by V26 LPN documents R15 had congestion, occasional wheezing, and a nonproductive cough. R15's Nursing Note dated 8/10/20 at 10:57 PM by V4 LPN documents R15 remains on droplet and contact isolation per Covid-19 precautions. R16's Nursing Noted dated 8/10/20 at 10:56 PM by V4 LPN documents R16 has no respiratory problems at this time. R7's Physician order [REDACTED]. R15's physician's orders [REDACTED]. once daily on Mondays. The facility's undated PPE Competency Validation documents when doffing PPE remove goggles or face shield and discard into the designated receptacle if re-processed or in the waste container. 2. On 8/6/2020 at 10:30 am a Calling Post Call letter dated 8/5/2020 was posted on the facility outside entrance door that stated the facility had identified two new residents and two more staff with symptoms of Covid-19. The notice stated The cumulative total for residents who have tested positive still remains at 45 and cumulative total for employees still remains at 29. On 8/10/2020 at 11:00 am the Calling Post Call letter dated 8/7/2020 on the front door stated the cumulative numbers were at 46 residents and 29 staff and one positive resident had been sent to the hospital. On 8/10/2020 at 11:45 am Housekeepers V21 and V22 were in the West South corridor with their housekeeping cart. V21 was wearing eyeglasses and a surgical mask and V22 was just wearing a surgical mask. V21 stated they had already cleaned the isolation rooms that morning. V21 stated she was training V22. V22 stated it was her first day of orientation on the floor. On 8/10/20 at 12:15 pm V21 and V22 were cleaning in R17's bedroom. R17 was not in quarantine or isolation. V21 and V22 were not wearing any eye protection. R17 was seated in a wheelchair in the middle of the room. R17 was not wearing a mask. V21 and V22 worked around R17 as they cleaned the room and were not maintaining a social distance of six feet. On 8/10/20 at 12:35 pm V9 Housekeeping Supervisor was asked what type of PPE the housekeepers should be wearing when they are cleaning the resident rooms. V9 stated housekeepers should wear full PPE face shield, masks, gowns and gloves for residents under Transmission Based Precautions (TBP). They should be wearing masks, face shields and gloves for cleaning other resident rooms and gowns are optional. V9 was informed at that time that V21 and V22 were observed cleaning in a resident room with a resident (R17) present and they were not wearing eye protection. On 8/10/20 at 12:45 pm V21 and V22 were in R14's room cleaning. R14 was not under Isolation/Quarantine precautions. V21 was wearing eyeglasses, a mask and gloves and V22 was wearing a mask and gloves. R14 was in the room in bed with head of bed elevated and R14 was wearing oxygen. V22 was mopping around the bed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145347	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GILMAN HEALTHCARE CENTER	**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)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) close proximity to R14, who was not wearing a mask. V9 who was present at that time told V21 and V22 that they should be wearing eye protection while cleaning in R14's room. V9 stated at that time V9 did not know if the written housekeeping policies specified wearing eye protection during cleaning of non isolation rooms. On 8/10/20 at 1:50 pm V9 stated she conferred with Administrator V1 who stated they did not have a written policy related to wearing eye protection when cleaning in non isolation resident rooms but V9 stated that V1 said the housekeeping staff should be wearing eye protection. R14's Progress notes from the night shift on 8/10/20 at 11:45 pm document that R14's pending Covid-19 test from 8/7/20 had come back positive. V21 and V22 eyes could have been exposed to [MEDICAL CONDITION] containing droplets when they were cleaning within a few feet of R14 on 8/10/20 at 12:45 pm. R14's progress notes dated 08/10/2020 11:45 PM documented received phone call from lab with positive Covid results, administrator and D.O.N. notified and immediately placed on contact and droplet precautions per facility Covid-19 protocol, will notify MD (medical doctor) in am (morning), res (resident) resting @ (at) this time with no s/s (signs/symptoms) and afebrile, will cont (continue) to monitor . R14's progress notes on 08/09/2020 08:00 AM documented Resident running a temp (temperature) of 101.4 this am. PRN (as needed)dose of APAP ([MEDICATION NAME]) given at 7:38 am. The notes documented R14's blood oxygen saturation level at 80-88% at 7:00 am. R14's oxygen flow was increased to 4.5 liters per minute which increased R14's oxygenation to 94-95% with no cough, shortness of breath or congestion noted. The note stated Resident voices no complaints. Hospice and P.O.A. (Power of Attorney) notified of resident's current condition. On 08/09/2020 progress notes document 03:10 PM Hospice nurse called and new orders received to start (Antibiotic [MEDICATION NAME]) ABT Z-pak as directed for possible URI (Upper Respiratory Infection). The on call physician had ordered the ABT with instructions to monitor R14 for symptoms and if they persist to update MD and Hospice. There was nothing documented in the progress notes on 8/9/20 about identifying R14 as a Person Under Investigation (PUI) or placing R14 under precautionary quarantine/isolation for R14's fever and upper respiratory symptoms on 8/9/20 even though the facility was experiencing an outbreak. R14's previous weekly COVID-19 Laboratory Test collected on 7/31/20 results on 8/1/20 reported as not detected (negative) on 8/1/20. The result states This result may be influenced by the stage of the [MEDICAL CONDITION] infection and the quality of the specimen collected for testing. Test result should be correlated in the clinical context of each patient. On 7/31/20 an Infection Control Educational Inservice training for COVID-19 was provided to facility staff by Director of Nurses (DON) V2. The training states At this time (subject to change) you only need to wear full PPE (Personal Protective Equipment) in Resident rooms who are quarantined or isolated. You are expected to follow standard precautions with all direct care. You are expected to wear your mask correctly at all times when in the building. You are to wear eye protection at all times. If providing direct care to residents they are to wear a mask. If they come out of their room for any reason they are to wear a mask. V21 had signed the 7/31/20 training attendance signature page. V1 Administrator stated on 8/11/20 at 12:00 pm that the housekeepers were not giving direct care to residents so were not required to wear eye protection. The facility Prevention of Coronavirus (Covid-19) Infection Control Policy Statement dated 6/2/20 states Healthcare Personnel (HCP) can minimize their exposure to COVID-19 by following IDPH (Illinois Department of Public Health and CDC (Center for Disease Control) infection control guidelines including use of recommended personal protective equipment (PPE). The policy also states, In general, for care of residents with undiagnosed respiratory infection (Person Under Investigation) PUI use Standard, Contact and Droplet Precautions with appropriate PPE to include face shield, face mask, gown and gloves.