Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003578	A. BUILDING: ______ B. WING ______	C 10/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILMAN HEALTHCARE CENTER	1390 SOUTH CRESCENT STREET, BOX 307 GILMAN, IL 60938

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S 000	Initial Comments Facility Reported Incident Investigations of 9/17/23/IL165200 of 9/27/23/IL165286	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 2 300.610a) 300.1210b 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care	S9999	**Attachment A** Statement of Licensure Violations	

Illinois Department of Public Health

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

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

Section 300.3210 General

t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property.

These requirements are not met as evidenced:

Based on interview and record review, the facility failed to prevent two episodes of physical abuse between residents for five of five residents (R1, R2, R8, R9 and R10) reviewed for abuse on the sample list of 10. This resulted in R1 hitting R2 on top of the head with a metal cane then R1 throwing a cup and eating utensils at R2, hitting R2 in the arm, causing psychosocial harm for R2 and R9, along with a hematoma to the top of R2's head.

Findings Include:

The facility's Abuse, Neglect and Exploitation Policy dated 2/28/23 documents, abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse include, but is not limited to hitting, slapping, punching, biting and kicking.

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The facility's Final Incident Report dated 9/22/23 documents on 9/17/23, it was reported that R1 and R2 were sitting in the dining room when R1 went over to R2 and struck R2 on the head with R1's cane. An investigation has been completed and staff interviews confirm that R1 struck R2 with R1's cane. R1 was not exhibiting any threatening behavior prior to R1's action and did not appear to even know why R1 had done so. R2 stated R1 hit R2 in the head with R1's cane. R2 does not know why R1 did this and reported that there was no altercation between them prior to this. R1 stated R1 doesn't know why R1 hit R1's peer (R2) and had no intention of hurting R2. Other residents present during this incident confirmed this incident, but none had any idea why R1 took this action.

On 10/12/23 at 9:05 am, R2 stated R2 was sitting in the dining room at dinner time when R1, who was at a different table but near R2, stood up and hit R2 on top of the head with R1's cane. R2 stated R2 had a large lump on R2's head and a headache after it happened. R2 explained the nurse put ice on it and sent R2 to the hospital for evaluation. R2 stated the lump went down with ice but that R2 had a headache for a couple of days. R2 also stated that after that happened, a couple weeks later, R1 threw R1's cup at R2 hitting R2 in the arm. R2 explained the facility then moved R1 to a different table, away from R2, but "it was too late, (R1) already had hit me (R2) a second time". R2 stated R2 was afraid of R1 explaining, "I (R2) don't want (R1) around me, I (R2) don't know what (R1) will do."

On 10/12/23 at 12:23 pm, V12 LPN (Licensed Practical Nurse) stated V12 was not present when R1 hit R2 with R1's cane however R1 told V12 about it saying R1 did it because R2 wouldn't

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talk to R1. V12 stated V12 explained that R2 was hard of hearing and that is probably why R2 didn't respond to R1. V12 then stated that after the first incident, V12 was told by V8 Activity Aide/CNA (Certified Nursing Assistant) that R1 threw R1's cups at R2 and hit R2 in the arm. V12 stated R2 is now afraid of R1.

On 10/12/23 at 12:39 pm, V8 stated V8 was in the dining room and when V8 walked by R2, who was sitting at the table along with R8, R9 and R10, R2 reported that R1 "just threw a glass and silverware at (R2)" that hit R2 in the arm. V8 explained R8, R9 and R10 all seen R1 throw items at R2, and thought it was wrong of R2 to throw the items. V8 stated V8 considers R1's actions to be abusive toward R2.

R9's MDS (Minimum Data Set) dated 9/20/23 documents R9 is alert and oriented.

On 10/12/23 at 1:47 pm, R9 stated R9, R2, R8 and R10 were all eating lunch when R1 threw a pop can at R2, hitting R2 in the upper arm, then a cup, that was not full was thrown and hit R2, then a knife that didn't hit R2 but instead landed on the floor, sliding under the table and then the rest of R2's utensils, which also hit the floor. R9 explained, "this isn't the first incident with (R1) either. A couple of weeks prior, (R1) was walking past (R2) and hit (R2) on top of (R2's) head with (R1's) metal cane." R2 ended up getting a big knot on the top of R2's head and instantly complained of a headache. R9 stated R2 is scared of R1 now and every time R1 walks past R2 at the table, R1 taunts R2 by telling R2 to look at something that isn't there. V9 explained V9 thinks R1 "is trying to be funny but that isn't funny after hitting (R2). (R1) could easily walk a different way but (R1) always walks right by (R2)

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and it's intimidating to (R2)." R9 stated we {R8, R9 and R10} all sit there and wonder "if it's going to be our turn next and that scares me (R9) because I'm in this wheelchair due to a broken ankle, I (R9) just can't get up and walk away from (R1)."

On 10/16/23 at 9:00 am, R1 confirmed R1 hit R2 over the head with R1's cane while in the dining room and stated R1 was upset, not necessarily at R2 but in general, and that is why R1 did it. R1 also confirmed R1 hit R2 with a cup in the dining room explaining that R1 did not throw the cup at R2 but instead swiped the table with his hand, pushing a cup and utensils off the table in R2's direction and was trying to hit R2 with them.

(B)

2 of 2

300.610a)
300.1210b)
300.1210d)6)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed

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and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced:

Based on observation, interview and record review, the facility failed to develop care plans and implement fall prevention interventions for residents at risk for falls and failed to thoroughly investigate a fall and implement appropriate post fall interventions for three of three residents (R5, R6 and R7) reviewed for falls on the sample list of 10. These failures resulted in R5 having multiple falls resulting in a compression fracture of L5.

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S9999	Continued From page 6 Findings Include: The facility Fall Prevention Program dated June 2023 documents the fall prevention program will be implemented to ensure all resident's safety in the facility whenever possible. This program should include a measure that determines each resident's needs by assessing the risks for falls and implementing appropriate interventions to provide the necessary supervision, and assistive devices are utilized as necessary. As part of the initial assessment, identify with a history of falls and risk factors for subsequent falling. Risk factors causing the fall should be identified. Identify the root causes of the fall incident, which could be related to the resident's current or declining medical condition or worsening behavior. For an individual who has fallen, staff will attempt to define possible root cause(s) of the fall. Contributing fractures can include but not limited to resident's gait, balance, and current medications that may be associated with dizziness or falling. Collect and evaluate any information until either the cause of the falling is identified or can be speculated as to what was the resident trying to do causing the fall, or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Based on the preceding assessment, the staff and or physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If the underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment until falling reduces or stops or until a reason is identified for its continuation. If the resident continues to fall, the staff and physician will re-evaluate the situation and consider other	S9999		

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possible reasons for the resident's falling (besides those that have already been identified) and will re-evaluate the continued relevance of current interventions.

1) R5's ongoing Census documents R5 was admitted to the facility on 9/22/23.

R5's undated Profile Sheet document the following diagnoses: Orthostatic Hypotension, Abnormalities of Gait and Mobility, Osteoarthritis, and Mild Cognitive Impairment.

R5's MDS (Minimum Data Set) dated 9/28/23 documents R5 has Moderately Impaired Cognition, is non-ambulatory and requires extensive assistance of one staff for bed mobility, transfers and locomotion.

R5's Fall Risk Assessments dated 9/22/23, 9/23/23, 9/26/23 and 9/27/23 all document R5 is at risk for falls.

R5's Care Plan dated 9/22/23 documents R5 is at risk for falls with interventions including: evaluate fall risk, determine ability to transfer, assist resident with transfers and ambulation.

R5's updated Care Plan dated 9/26/23 documents R5 has had an actual fall with minor injury due to Poor Balance, Unsteady gait, and confusion with interventions to continue interventions on the at-risk plan, dump wheelchair, encourage to sit in more visual area, remove foot pedals, and send to ER (Emergency Room) for further evaluation.

On 10/11/23 at 11:32 am, hanging on the wall in R5's room, at the head of the bed were two signs. One documents "Call don't fall". The second sign,

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which was hanging upside down in the same location documents "If you need help, please push the red button on your call light and wait for help."

R5's Progress Notes document the following:
9/23/23 - Housekeeping staff alerted RN (Registered Nurse) that R5 was on the floor. Upon getting to R5, R5 was noted lying on the floor. R5 stated that R5 was attempting to get up to go look for her husband. R5 is weak and ended up sliding out of the wheelchair.
9/26/23 - noted to be on floor by DON (Director of Nursing) and CNA (Certified Nursing Assistant). R5 was did not have footwear on, call light was within reach.
9/27/23 two entries, both by V6 RN - 1) notified by another resident that R5 was on the floor. When leaving dining room and looking down hall, noticed R5 sitting on the floor, against the wheelchair with R5's right leg bent up on leg rest and 2) was notified by another resident that R5 fell out of the wheelchair in the dining room. Upon entering, R5 was noted to be on the floor, leaning up against the wheelchair with R5's head resting on the seat. R5 did not have shoes on. Other staff members assisted R5 back into the wheelchair and R5 was placed near nurses station. R5 denies pain and hitting R5's head. Given order to send to the hospital.

On 10/12/23 at 11:30 am, V2 DON stated R5 was originally admitted to the facility due to falling at home and R5's husband not being able to take care of her. V2 explained R5 is very impulsive and thinks R5 can do things for herself because R5 is wanting to go back home to her husband. V2 provided more details related to the above falls. V2 explained on 9/23/23, R5 was on the floor near the hallway bathroom, after sliding out

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S9999	Continued From page 9 of R5's wheelchair while looking for her husband. V2 stated a new intervention was implemented to sit in a more visual area. V2 confirmed the intervention was not appropriate as sitting in a more visualized area would not prevent R5 from sliding out of the chair. V2 explained on 9/26/23, R5 was attempting to get out of bed by R5's self and was found on the floor. V2 stated V2 is unsure why R5 was trying to get up out of bed because V2 didn't investigate the fall or talk to the resident about the fall but instead just went off of the witness statement which documented that she was wanting to get dressed. V2 stated a new intervention of visual cues were posted in R5's room to call for assistance. V2 confirmed that the visual cues should be some place that R5 can see them, other than being behind R5's head, and positioned so R5 can read them. V2 stated V2 is only aware of one fall on 9/27/23 and "that is the one where (R5) sustained the fracture and it was reported to IDPH (Illinois Department of Public Health." V2 stated V2 only has one incident report from that day, and it was for the fall that occurred at 7:15 pm, in the hallway, when R5 slipped out of the wheelchair. V2 believes R5 was trying to get the foot pedals off of the wheelchair so the new intervention was to remove the foot pedals and dump the seat of the wheelchair. V2 stated no interventions were implemented for the other fall that day, as V2 was not aware of a second fall. R5's Emergency Department Adult Provider Note dated 9/28/23 by V9 Hospital Physician documents R5 was brought to the Emergency Room on 9/27/23 after trying to lift R5's self up from a wheelchair, slipped and fell to the floor from the wheelchair. R5 is complaining of pain to the lower back. This note documents R5 has an acute L5 compression fracture.	S9999		

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R5's Radiology Results dated 9/27/23 documents "there is minimal height loss and a faintly visible fracture line through the superior endplate of L5 consistent with an acute compression fracture."

2) On 10/11/23 at 1:30 pm, R6 was lying in bed with a seated walker next to the bed. R6 stated the last time R6 fell, R6 had bent down to pick something up off the floor and R6's knee gave out, explaining R6 has two "bad" knees that "give out at times".

R6's October 2023 Physician Orders document an order on 10/2/23 to wear a soft knee brace for pain.

R6's MDS (Minimum Data Set) dated 9/12/23 documents R6 has moderately impaired cognition and requires supervision with transfers and ambulation.

R6's Progress Notes dated 10/6/23 documents R6 sitting on buttocks on the floor in the dining room. R6 stated R6's right knee gave out. Fall was witnessed by other residents in the dining room.

On 10/12/23 at 10:52 am, V2 DON (Director of Nursing) stated R6's fall was not investigated, and no new post fall interventions were implemented.

3) R7's ongoing Census documents R7 was admitted to the facility on 9/18/23.

R7's Fall Risk Assessments dated 9/18/23 documents R7 is at risk for falls.

R7's Care Plan dated 10/2/23 does not contain an

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S9999	Continued From page 11 at risk for falls care plan or any fall prevention interventions. On 10/12/23 at 11:12 am, V2 DON (Director of Nursing) confirmed R7 does not have an at risk care plan for falls and did not have any fall prevention interventions put into place at the time of admission, even though R7 was at risk for falls at the time of admission to the facility. V2 stated R7 should have had one in place with standard fall prevention interventions. (B)	S9999		