

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Initial Comments Complaint Investigation #1961948/IL110485	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610 300.1210b) 3001210d)1)2) 300.1620a) 300.3240a) 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. 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.	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 04/07/19
--	-------	-----------------------

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 1</p> <p>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:</p> <p>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1620 Compliance with Licensed Prescriber's Orders</p> <p>a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These Regulations were not met as evidenced by: Based on interview and record review the facility failed to administer antiseizure medications as ordered for one resident (R1). This failure resulted in R1 experiencing seizures for three days and being hospitalized in the Intensive Care Unit with uncontrolled seizures. The facility also failed to give an IV (intravenous) antibiotic as ordered for R1. R1 was one of three residents reviewed for medications in the sample of three.</p> <p>Findings include:</p> <p>The facility's Controlled Substance Prescriptions policy dated 10/25/14 documents, "Before a</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
S9999	Continued From page 2 controlled drug can be dispensed, the pharmacy must be in receipt of a clear, complete, and signed written prescription from a person lawfully authorized to prescribe." This policy also documents, "New Controlled Substance Prescriptions: For emergency controlled substance orders, the nurse will review the Emergency Kit list for available medications prior to contacting the prescriber. The nurse will communicate to the prescriber the emergency medication available to provide appropriate care to the patient." This policy goes on to document, "If the medication is not available in the emergency kit, the nurse contacts the pharmacy using the after-hours emergency number(s) if necessary." Also, "Emergency/STAT (immediate) Medication order (Medication not contained in Emergency Medication Supply). a. An emergency/STAT order is placed and validated with (pharmacy provider) and the medication is scheduled to be given as soon as received or within four (4) hours, whichever is sooner. Subsequent doses are scheduled according to facility policy." The facility's Admission Criteria policy dated December 2012 documents, "Prior to or at the time of admission, the resident's Attending Physician must provide the facility with information needed for the immediate care of the resident, including orders covering at least: a. type of diet, b. medication orders, c. routine care orders." The facility's Medication Error Event for R1 with a recorded date of 3/20/19 documents, "R1 admitted to the facility with orders for Vimpat (anticonvulsant/controlled substance) and Onfi (benzodiazepine used to treat seizures/controlled substance) which both require a prescription.	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/27/2019
NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
S9999	<p>Continued From page 3</p> <p>Scripts (prescriptions) were not (obtained) (R1) did not receive (R1's) medication." This report documents the error began on 3/16/19 and ended on 3/18/19.</p> <p>According to R1's Resident Face Sheet, R1 was admitted to the facility on 3/15/19 at 5:59 PM. R1's Medication Administration History dated 3/1/19 through 3/25/19 documents R1 received one medication on 3/15/19 which was calcium. No other medications were given on 3/15/19. This Administration History documents R1 was admitted with diagnoses including Cellulitis, Poisoning by Hydantoin Derivatives, Accidental, Infection following a Procedure, Lennox-Gastaut Syndrome, Epilepsy, Hypothyroidism, Presence of other Specified Devices-Vagus Nerve Stimulator, Profound Intellectual disabilities and Pneumonitis due to Inhalation of Food and Vomit.</p> <p>R1's POS dated 2/25/19 through 3/25/19 documents orders for Onfi tablet 20mg (milligrams), two tablets twice a day at 8:00 AM and 8:00 PM and Vimpat 150mg two tablets twice a day at 8:00 AM and 6:00 PM. The order start date for these medications is 3/16/19. R1 was admitted to the facility on 3/15/19. The medications were ordered on discharge from the hospital on 3/15/19.</p> <p>R1's Medication Administration History dated 3/1/19 to 3/25/19 documents: Onfi 20 mg(milligram) give two tablets twice a day was not given on 3/15/19, 3/16/19, 3/17/19, or 3/18/19 with the reason documented on the Medication Administration History as "drug/item unavailable"; Vimpat 150 mg give two tablets twice a day was not given on 3/15/19 at 6:00 PM, on 3/16/19 and 3/17/19 at 8:00 AM and 6:00 PM and on 3/18/19 at 8:00 AM with the reason documented as</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 4</p> <p>"drug/item unavailable."</p> <p>R1's Nurses Progress Note dated 3/16/19 at 12:24 PM by V3 Registered Nurse (RN) documents, "X (times) 2 1 minute seizures noted during the shift." R1's Nurses Progress Note dated 3/17/19 at 10:51 AM by V5 documents, "(R1) had seizure episode while in w/c (wheelchair) by the nurses station for about 2 (minutes)." R1's Nurses Progress Note dated 3/17/19 at 10:48 PM by V18 LPN documents, "(R1) had 3 seizures between 4:30p(PM)-5:30p."</p> <p>R1's Nurses Progress Note dated 3/18/19 at 8:30 AM by V6 Assistant Director of Nursing documents, "Called MD (Medical Doctor) office regarding narcotic script request and asked if MD had received them. Secretary stated they were sorting through 50 (plus) faxes they had received over the weekend. Reported to secretary that (R1) was having seizures and it was very important that MD signs and faxes the narc (narcotic) scripts back ASAP (as soon as possible). She stated she would get them over as soon as she could and that MD wasn't going to be in the office until 10:45 AM."</p> <p>R1's Nurses Progress Note dated 3/18/19 at 1:02 PM by V7 Registered Nurse documents, "Several attempts made to contact (V4) (R1's facility Physician) regarding (R1's) change in condition, no call back as of yet. VS (vital signs) are as follows BP (blood pressure) 98/71, HR (heart rate) 80, RR (respiratory rate) 16, T (temperature) 97.9. No oral intake tolerated, (R1) unable to eat or be assessed by ST (speech therapy). (R1) has had several seizures throughout shift." This note also documents, "Messages left for (V4)." "(R1) has been sent to the (hospital) via ambulance."</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 5</p> <p>R1's Nurses Progress Note dated 3/18/19 at 1:33 PM by V7 documents, "Spoke to (V4) on telephone regarding (R1's) Vimpat and Onfi orders. (V4) stated that (V4) is not comfortable signing for said medication because they are not (V4's) orders. Orders originally given per (hospital physician) prior to admission to this facility." R1's Nurses Progress Note dated 3/18/19 at 2:26 PM by V7 documents, "(Hospital) called to verify that (R1) has not received Vimpat or Onfi medications since (R1's) arrival. (R1) was admitted to this facility from the (hospital) without the hard copy for those medications and this facility was unable to obtain said medications."</p> <p>R1's Emergency Department Course/Medical Decision Making documentation dated 3/18/19 at 1:53 PM by V12 hospital Physician, documents, "It has been found that (R1) has not had any of (R1's) IV (intravenous) antibiotics or seizure medication for at least the last 48 to 72 hours. At this time, (R1) requires (R1's) medication to get (R1's) seizures under control and make sure (R1's) infection is under control."</p> <p>R1's Nurses Progress Note dated 3/18/19 at 2:26 PM by V7 Registered Nurse (RN) documents, "(Hospital) called to verify that (R1) has not received (Vimpat) or Onfi medications since (R1's) arrival. (R1) was admitted to this facility from (Hospital) without the hard copy for those medications and this facility was unable to obtain said medications. This writer (V7) notified RN calling from ED (Emergency Department) of this situation."</p> <p>R1's hospital History and Physical dated 3/19/19 at 9:39 AM by V13 hospital Physician documents, "Apparently over the weekend (R1) could not get (R1's) seizure medication so (R1) started having</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 6</p> <p>seizures yesterday at the (nursing facility) so (R1) was sent to the emergency room and was admitted to the floor. (R1) was transferred to ICU (Intensive Care Unit) where (R1) has been intubated, having IV (intravenous) sedatives also."</p> <p>R1's EEG (Electroencephalogram) dated 3/19/19 by V14 hospital Physician documents, "This is a very abnormal EEG in the sedated state. There is presence of eight electrographic seizures at least one of which was subclinical the others being convulsive in nature. This represents status epilepticus." This also documents, "(R1) needs continuous EEG, have to transfer to (a larger hospital)."</p> <p>On 3/25/19 at 10:55 AM, V3 Registered Nurse stated the hospital is supposed to send paper scripts with the resident but the hospital did not send them with R1 for the Onfi and Vimpat. V3 stated V3 did not contact the hospital for the written scripts. V3 stated that V3 faxed V4 R1's Physician for written scripts for the Onfi and Vimpat but did not get a reply from V4.</p> <p>On 3/25/19 at 11:15 AM, V2 Director of Nursing stated they have to have medication orders to the pharmacy by 10:00 PM to receive the medications at the 5:00 AM delivery time. They have some back up medications in the facility but V2 stated V2 is unaware if R1's medications were in the back up supply. V2 stated they can use the facility's pharmacy for back up for stat (immediate) orders and get them with in four hours. V2 confirmed R1 did not admit with the needed prescriptions from the hospital and it is their practice that the nurse admitting the resident should contact the hospital discharging the resident to get the needed prescriptions. V2</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 7</p> <p>confirmed there is no documentation that anyone contacted the discharging hospital for the needed prescriptions for R1. V2 stated that V4 R1's Physician can take awhile to return their phone calls. V2 stated the hospitals are good about sending admissions on Fridays after 6:00 PM and it is difficult to get medications at that time.</p> <p>On 3/25/19 at 12:24 PM V5 Licensed Practical Nurse (LPN) stated V5 did not contact the hospital regarding the prescriptions since V6 entered the medication orders.</p> <p>On 3/25/19 at 1:47 PM, V6 Assistant Director of Nursing stated V6 assisted with R1's admission from V6's home. V6 stated V6 entered R1's medications into the computer. V6 stated after the medications were entered V6 notified V5 LPN through text messaging that R1's medications were in the computer and V5 needed to fax them to the pharmacy. V6 confirmed the nurse should have contacted the hospital where R1 was discharged regarding the paper prescriptions for the Onfi and Vimpat. V6 stated, "unfortunately calling V4 on Friday at 6:00 or 7:00 PM is not the easiest time to get ahold of V4."</p> <p>On 3/26/19 at 2:45 PM, V17 Pharmacist confirmed by R1 not receiving the seizure medications, Onfi and Vimpat, that could've caused R1 to have seizures. V17 stated Vimpat's half life (the time it takes for half the medication to be metabolized and eliminated from the blood stream) is 10.6 to 13 hours depending on the resident's weight. V17 stated the half-life of Onfi is 36 hours. V17 confirmed they have trouble getting paper prescriptions from Physicians over the weekends. V17 stated Vimpat and Onfi are controlled substances and require a script but V17 stated the Physician could have given them a</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
S9999	<p>Continued From page 8</p> <p>verbal order for these two medications due to their class. V17 stated if the pharmacy had received the verbal order from the Physician or written script for the Onfi and Vampit and the nurse would have called them for a stat order, the pharmacy could have sent the medications within 4 hours.</p> <p>The manufacturer's information provided by the pharmacy printed 3/26/19 for Vimpat documents the Discontinuation of therapy: As with all AEDs (Antiepileptic drugs), gradually withdraw lacosamide (Vimpat) over a minimum of 1 week to minimize the potential of increased seizure frequency in patients with seizure disorders." The manufacturer's information provided by the pharmacy printed 3/26/19 for Onfi documents the Discontinuation of therapy: Withdraw gradually by decreasing the total daily dosage by 5 to 10 mg/day on a weekly basis until discontinued.</p> <p>On 3/25/19 V2 Director of Nursing provided an addendum to R1's medication error dated 3/20/19 which documents, "Please refer to med (medication) error created on 3/20/19. In addition to meds (medications) mentioned add Zosyn (antibiotic), Synthroid (hormone for the thyroid gland)." This addendum was signed by V2.</p> <p>R1's POS dated 2/25/19 through 3/25/19 documents orders for Synthroid 150mcg (micrograms) one tablet orally once a day at 5:00 AM and Zosyn (antibiotic) reconstituted solution 4.5 grams Intravenously every six hours at 8:00 AM, 2:00 PM, 8:00 PM and 2:00 AM. The order start date for these medications is 3/16/19. R1 was admitted to the facility on 3/15/19. The medications were ordered on discharge from the hospital on 3/15/19.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 9</p> <p>R1's Nurses Progress Notes dated 3/15/19 at 6:00 PM by V5 Licensed Practical Nurse (LPN) documents R1 was admitted to the facility from the hospital and R1 had a PICC (Peripherally Inserted Central Catheter) line to the left arm, "intact and patent."</p> <p>R1's Medication Administration History dated 3/1/19 to 3/25/19 documents Synthroid 150 mcg (micrograms) give one tablet once a day was not given on 3/16/19 or 3/17/19 with the reason documented on the Medication Administration History as "drug/item unavailable"; Zosyn 4.5 gram intravenous every six hours was not given on 3/15/19 at 8:00 PM, 3/16/19 at 2:00 AM, 8:00 AM, 2:00 PM, 8:00 PM, 3/17/19 at 2:00 AM, 8:00 AM, 2:00 PM, 8:00 PM, 3/18/19 at 2:00 AM, 8:00 AM, 2:00 PM with the reasons documented on the Medication Administration History as "drug/item unavailable and intravenous site unavailable"</p> <p>R1's Nurses Progress Note dated 3/15/19 at 6:00 PM by V5 LPN documents, "Has Picc line to left arm, intact and patent. Dressing to left chest, intact, dry and clean. On IV (intravenous) ABX (antibiotics) (due) to left chest wound infection."</p> <p>R1's Progress Note dated 3/16/19 at 12:24 PM by V3 RN (Registered Nurse) documents, "RN contacted MD (Medical Doctor) due to resident not having an access site for IV antibiotics, MD gave a telephone order to send resident to the (hospital) interventional radiology department for PICC insertion, upon contacting the (hospital), RN was notified by operator that IR (interventional radiology) is only open (until) noon on the weekends and to call IR and leave message."</p> <p>R1's Emergency Department Course/Medical</p>	S9999		
-------	---	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	<p>Continued From page 10</p> <p>Decision Making documentation dated 3/18/19 at 1:53 PM by V12 documents R1 did not have any of R1's IV antibiotic medication for at least 48 to 72 hours and R1 requires that medication to make sure R1's infection is under control.</p> <p>On 3/25/19 at 10:55 AM, V3 RN stated according to R1's medical record R1 admitted with a PICC line but it was not there when V3 completed R1's assessments on 3/16/19. V3 stated no one knew what happened to the access site.</p> <p>On 3/25/19 at 11:15 AM, V2 Director of Nursing stated R1 had a PICC line on admission but it was gone in the morning on 3/16/19 and no one knew what happened to it.</p> <p>On 3/25/19 at 12:24 PM, V5 Licensed Practical Nurse (LPN) stated R1 had a PICC line when R1 admitted to the facility on 3/15/19. V5 stated V5 assisted with R1's shower and saw the PICC line then. V5 stated V6 Assistant Director of Nursing assisted V5 with the admission and V6 put the medications in the system so V6 should've faxed them to the pharmacy and V6 should've known R1 needed to receive the IV meds at 2:00 AM. V5 stated R1's Zosyn (antibiotic) was Intravenous and V5 had no idea how the PICC line was gone on 3/17/19.</p> <p>On 3/25/19 at 1:47 PM, V6 Assistant Director of Nursing stated V6 knew R1 had an IV (intravenous) ordered but no one notified V6 that there was no Registered Nurses available at the facility to administer the IV.</p> <p>On 3/27/19 at 9:55 AM, V4 R1's Physician stated if the hospital started the IV antibiotic the facility should have continued it. V4 stated the hospital should have sent paper prescriptions with R1. If</p>	S9999		
-------	--	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6003578	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/27/2019
--	---	---	---

NAME OF PROVIDER OR SUPPLIER GILMAN HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S9999	Continued From page 11 they did not then the facility should have followed up with the hospital to get those prescriptions. V4 stated that R1 not receiving the Onfi and Vimpat could have caused R1 to have seizures. V4 stated if R1 would have gotten the anticonvulsant medications R1 probably would have been fine. (A)	S9999		
-------	---	-------	--	--