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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	F 000		
F 159 SS=E	Annual Licensure and Certification Survey 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		

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

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F 159	Continued From page 1 The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide evidence that it had established a method of accounting to preclude commingling of resident funds with facility funds, and failed to provide documentation that each resident's personal funds are individually accounted for. These failures effect nine residents (R2, R4, R8, R10, R12, R13, R19, R21, and R24) reviewed for resident funds on the sample of fifteen, and forty-one residents (R3, R5, R7, R9, R11, R14, R18, R28, R29, R30, R33, R34, R35, R37 through R42, and R44 through R65) on the supplemental sample. Findings include: The facility's Trust Fund Balance Reports dated 6/3/16 and 5/31/16 documents an ending balance and a beginning balance for each resident for whom the facility manages personal funds. These same Balance Reports do not document individual transactions, receipts, nor deposits for each resident. On 6/17/16 at 8:48 am E17, Social Services	F 159		

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F 159	Continued From page 2 Designee, stated, "I don't have anything to do with the main deposits. All of that is handled by our corporate office in Skokie. The resident Social Security checks go into a main bank in Skokie, then each resident's monthly personal needs allowance funds ($30.00) gets deposited into our local bank. I just manage the requests for petty cash here, then send corporate the amounts of each resident's request for petty cash." The facility's bank statements dated 3/31/16, 4/29/16, and 5/31/16 from Midwest Bank of Skokie, Resident Personal Funds Account, account number ******1535, document transfers from another Midwest Bank of Skokie account number ******1394, which are lump sum transfers of less than $600.00, but do not document the source of these deposits, nor document where the resident's financial assistance and social security checks are deposited, and do not document the amount of interest a resident should be entitled to from the deposit of their individual financial assistance checks and social security checks. Upon request, the facility did not provide bank statements from the Midwest Bank of Skokie Account number ******1394. On 6/17/16 at 11:00 am, E1, Administrator, stated, "This is what corporate sent us (for the resident's ledgers and bank statements)."	F 159		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final	F 160		

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F 160	Continued From page 3	F 160		

accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to convey residents personal funds to the resident's estate within thirty days after the resident's death. This failure effects three residents (R38, R39, R40) on the supplemental sample.

Findings include:

The facility's Admit/Discharge Report dated 6/14/16 documents R38 expired on 5/13/16.

The facility's Trust Account Balances dated 6/14/16 documents R39 was discharged on 3/3/16, R40 expired on 4/11/16, and confirms R38 was discharged on 5/13/16. This same Trust Account Balances documents R38 has $271.02 remaining in the trust account, R39 has $105.00 remaining in the trust account, and R40 has $113.01 remaining in the trust account.

On 6/17/16 E17, Social Services Designee, stated, "(R38) did expire on 5/13/16, (R39) did expire on 3/3/16, and (R40) did expire on 4/11/16. E17 continued, "(R38) and (R39) are still (state financial assistance program) pending, I thought I was supposed to wait to see if they became approved before transferring the money out of their account." E17 concluded by stating, "I have not sent a request for a Small Estate Affidavit for (R40) yet."

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F 161	Continued From page 4	F 161		
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide evidence that their surety bond was an amount sufficient to cover the entirety of resident funds managed by the facility. These failures effect nine residents (R2, R4, R8, R10, R12, R13, R19, R21, and R24) reviewed for resident funds on the sample of fifteen, and forty-one residents (R3, R5, R7, R9, R11, R14, R18, R28, R29, R30, R33, R34, R35, R37 through R42, and R44 through R65) on the supplemental sample. Findings include: The facility's Surety Bond number 2182431 dated 5/1/2014 documents the facility maintains a surety bond to protect resident personal funds in the amount of $20,000.00. On 6/17/16 at 8:48 am E17, Social Services Designee, stated, "I don't have anything to do with the main deposits. All of that is handled by our corporate office in Skokie. The resident social security checks go into a main bank in Skokie, then each resident's monthly personal needs allowance funds ($30.00) gets deposited into our local bank. I just manage the requests for petty cash here, then send corporate the amounts of	F 161		

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F 161	Continued From page 5 each resident's request for petty cash." The facility's bank statements dated 3/31/16, 4/29/16, and 5/31/16 from Midwest Bank of Skokie, Resident Personal Funds Account, account number ******1535, document a highest daily balance from the account number ******1535 was $3,270.61 on 3/9/16. These same bank statements document transfers from a second account at Midwest Bank of Skokie account number ******1394. The facility's local bank statements for Resident Funds dated 3/31/16, 4/29/16, and 5/31/16 account number ***253 documents a highest daily balance of $8,969.73 on 5/23/16. None of the facility's bank statements document the amounts of these 50 resident's state financial assistance checks nor resident's Social Security checks into account ******1394 or ******1535. Upon request, the facility did not provide bank statements from the Midwest Bank Account number ******1394. On 6/17/16 at 11:00 am, E1, Administrator, stated, "This is what corporate sent us (for the resident's ledgers and bank statements)."	F 161		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		

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F 225	Continued From page 6	F 225		

of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to form a suspicion of a crime, report and investigate 132 doses of missing morphine. These failures affected one of three residents (R22) reviewed for liquid morphine administration on the sample of 15.

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F 225	Continued From page 7 Findings include: R22's Physician Order Sheet (POS) dated June 2016, documents the following diagnoses and medication order: Malignant Neoplasm Unspecified Bronchus Lung, History of Chemotherapy, Chronic Pain and Palliative Care. The same POS documents orders for (liquid) Morphine 100 milligrams (mg) per milliliter (ml), administer 0.1 ml (10 mg) sublingual (sl) every six hours routinely and Morphine 100 milligrams (mg) per milliliter (ml), administer 0.1 ml (10 mg) sl every two hours as needed for pain. The Minimum Data Set (MDS) for R22 dated 4/21/16 documents that R22 is moderately cognitively impaired. On 6/14/16 at 1:00 pm E13, Licensed Practical Nurse administered R22's liquid Morphine 100 mg/ml, 0.1 ml, sl. E13 went to record the dose given and the remainder of Morphine in the bottle on the "Controlled Drug Record, Individual Patient's Narcotic Record" sheet. E13 did not measure the remainder and documented 8.0 ml and put a question mark after the entry. E13 stated "we just eyeball the bottle." The Patient's Narcotic Record sheet documented the previous administration remainder as 12.3 ml (123 doses). On 6/14/16, immediately after E13 administered the liquid Morphine to R22, E3, Director of Nursing (DON) and E4, Assistant DON re-measured the Morphine, using a syringe. There were two bottles of R22's Morphine opened and measured. The first bottle was the bottle E13 had just used to administer R22's liquid Morphine at 1:00 pm. Bottle number one was measured as	F 225		

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F 225	Continued From page 8	F 225		

7.3 ml. The Narcotic Flow Sheet documents this bottle number one should contain 12.3 ml. Bottle number one is 5.0 ml short. Bottle number two should contain 10 ml. as recorded on the narcotic record sheet. Bottle number two was also measured as 7.3 ml. Bottle number two is short 2.7 ml. R22's "Controlled Drug Record, Individual Patient's Narcotic Record" sheet also documented an entry correction of the Morphine count on 6/12/16 as a shortage of an additional 1.3 ml (13 doses) and on 6/13/16 an entry count correction of 4.2 ml (42 doses) shortage. The total Morphine missing, after review of the Medication Administration Record and the Narcotic Record sheets, totaled 13.2 ml (132 doses) from 6/12/16 to 6/14/16. These 13.2 ml were confirmed by E3, DON and E4, ADON when they measured the quantity of R22's liquid Morphine.

On 6/15/15 at 11:00 am E4 ADON stated "It is an error in counting, eyeballing the (R22's) morphine instead of using the syringe."

On 6/16/16 at 11:50 am E3 DON stated "The first 1.3 ml (13 doses) short on 6/12/16, I thought was due to inaccurate measuring... On 6/13/16 I was not notified of the 4.2 ml (42 doses) of Morphine missing, therefore I did not investigate... I became aware of the 7.7 ml (77 doses) missing (6/14/16) and investigated it as a measuring issue..."

On 6/16/16 at 12:03 pm E1, Administrator, stated "On 6/14/16, I was made aware of the discrepancy of the narcotic count sheet for (R22's) Morphine. At that time the DON (E3), ADON (E4) and (E18) the Corporate Nurse began investigating to reconcile the count and

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F 225	Continued From page 9 correct the documentation....I was under the impression this was a documentation issue and not a missing medication issue therefore I had not filed a report..." The facility policy "Staff Responsibility for Coordinating/ Implementing Abuse Prevention Program Policies and Procedures" dated August 2011 documents the following: "The Administrator is responsible for overall coordination and implementation of our facility's abuse prevention program policies and procedures...It is the responsibility of our employees, facility consultants, attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management...Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent....All suspected violations and all substantiated incidents of abuse will be immediately reported to the appropriate state agencies and other entities or individuals as may be required by law...(which include) the State licensing / certification agency responsible for surveying / licensing the facility....Law enforcement officials....The Administrator, Director of Nursing, or any other designated individual will report within the required time frames, any suspicion of a crime against a resident to the State Survey Agency and local law enforcement agency..."	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		

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F 226 SS=D	Continued From page 10 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to operationalize their Abuse Prevention Policy by failing to form a suspicion of a crime, report and investigate 137 missing doses of R22's liquid Morphine. These failures affected one of three residents (R22) reviewed for liquid morphine administration on the sample of 15. Findings include: The facility policy "Staff Responsibility for Coordinating/ Implementing Abuse Prevention Program Policies and Procedures" dated August 2011 documents the following: "The Administrator is responsible for overall coordination and implementation of our facility's abuse prevention program policies and procedures....It is the responsibility of our employees, facility consultants, attending Physicians, family members, visitors etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management...Misappropriation of resident property is defined as the deliberate	F 226		

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F 226	Continued From page 11 misplacement, exploitation, or wrongful, temporary, or permanent use of resident's belongings or money without the resident's consent....All suspected violations and all substantiated incidents of abuse will be immediately reported to the appropriate state agencies and other entities or individuals as may be required by law...(which include) the State licensing / certification agency responsible for surveying / licensing the facility....Law enforcement officials....The Administrator, Director of Nursing, or any other designated individual will report within the required time frames, any suspicion of a crime against a resident to the State Survey Agency and local law enforcement agency..." On 6/14/16 at 1:00 pm E13, Licensed Practical Nurse, administered R22's Morphine 100 mg/ml (milliliter), 0.1 ml. E13 went to record the dose given and the remainder of Morphine in the bottle on the "Controlled Drug Record, Individual Patient's Narcotic Record" sheet. E13 did not measure the remainder and documented 8.0 ml and put a question mark after the entry. E13 stated "we just eyeball the bottle. "The Patient's Narcotic Record sheet documented the previous administration remainder as 12.3 ml (123 doses). On 6/14/16, immediately after E13 administered the liquid Morphine to R22, E3, Director of Nursing (DON) and E4, Assistant DON re-measured the Morphine, using a syringe. There were two bottles of R22's Morphine opened and measured. The first bottle was the bottle E13 had just used to administer R22's liquid Morphine at 1:00 pm. Bottle number one was measured as 7.3 ml. The Narcotic Flow Sheet documents this	F 226		

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bottle number one should contain 12.3 ml. Bottle number one is 5.0 ml short. Bottle number two should contain 10 ml. as recorded on the narcotic record sheet. Bottle number two was also measured as 7.3 ml. Bottle number two is short 2.7 ml. R22's "Controlled Drug Record, Individual Patient's Narcotic Record" sheet also documented an entry correction of the Morphine count on 6/12/16 as a shortage of an additional 1.3 ml (13 doses) and on 6/13/16 an entry count correction of 4.2 ml (42 doses) shortage. The total Morphine missing, after review of the Medication Administration Record and the Narcotic Record sheets, totaled 13.2 ml (132 doses) from 6/12/16 to 6/14/16. These 13.2 ml were confirmed by E3, DON and E4, ADON when they measured the quantity of R22's liquid Morphine.

On 6/15/15 at 11:00 am E4, ADON stated "It is an error in counting, eyeballing the (R22's) morphine instead of using the syringe.."

On 6/16/16 at 11:50 am E3, DON stated "The first 1.3 ml (13 doses) short on 6/12/16, I thought was due to inaccurate measuring...On 6/13/16, I was not notified of the 4.2 ml (42 doses) of Morphine missing, therefore I did not investigate...I became aware of the 7.7 ml (77 doses) missing (6/14/16) and investigated it as a measuring issue..."

On 6/16/16 at 12:03 pm E1, Administrator stated "On 6/14/16, I was made aware of the discrepancy of the narcotic count sheet for (R22's) Morphine. At that time the DON (E3), ADON (E4) and (E18) the Corporate Nurse began investigating to reconcile the count and correct the documentation...I was under the impression this was a documentation issue and

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F 226	Continued From page 13 not a missing medication issue, therefore I had not filed a report (Abuse)..." The Resident Census and Conditions of Residents report dated 6/14/16 documents 64 residents reside in the facility.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility staff failed to respect resident dignity by failing to follow the cell phone usage policy during resident care. This affected three residents (R2, R13, R20) reviewed for dignity in the sample of 15 and six residents in the supplemental sample (R30-35). The findings include: On 6/14/16 at 11:45 am R13 stated that one of the Certified Nurse Aides (CNA), E7 answered a cell phone call while caring for R13 in the bathroom. R13 stated he also thought that E7 was smoking a cigarette. R13 stated he is blind so he could not see if there was a cigarette but could smell smoke. R13 stated that E7 told R13 not to tell anyone what happened. R13 stated this happened approximately two weeks ago. R13 stated that he reported this in the Resident Council meeting this morning (6/14/16).	F 241		

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F 241	Continued From page 14 The Resident Council Minutes dated 6/14/16 under new business states "At times cell phones are still being used in resident's rooms and the residents feel there should be another in-service since we have new staff...A man stated he has an issue with a CNA possibly smoking in his bathroom and talking on a cell phone. This writer told him she had to report this to the Administrator and did." On 6/15/16 at 9:45 am during the resident Group Interview residents (R20, R30, R31, R32, R33, R34, R35) voiced concerns with staff use of cell phones while working. R35 stated that when staff come in to work she thinks they should check their cell phones at the door. R33 stated that staff have come into his room and shut the door to use their cell phone because there is no security camera in the rooms. R33 stated he has seen a CNA pushing a resident into the dining room and stop to answer a cell phone text before taking the resident to the table. R39 stated "We don't pay the staff to talk on their cell phones." Residents also reported staff call each other to coordinate "smoking" breaks. The residents stated it has been an ongoing problem and has been reported in the Resident Council several times. On 6/15/16 at 3:30 pm CNA E6 responded to a nurse call light test in R2's room. E6 was asked what the cell phone usage policy was. E6 stated they are not supposed to use cell phones during work. When asked if E6 was carrying a cell phone he stated "Yes" and pulled it out of his pocket. E6 stated "I use it for a watch, it is a bad habit I shouldn't have it on me." The April 12, 2016 Resident Council Minutes	F 241		

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documents "We have noticed serveral new faces here and want it known that the cell phones are still a huge issue with the residents as they feel it takes away from their care."

The March 8, 2016 Resident Council Minutes document "There were several resident who stated they know staff was inserviced on not using cell phones during care and going out together in groups with no one to answer call lights. The residents gave examples..It was suggested by the residents that a follow up be done and that just telling them and having them sign something is not helping this group at this time."

The February 15, 2016 Resident Council Minutes document "The residents know there have been several training in services on rules for use of cell phones ..but after a few days it is still going one and one man stated they answer their cell phones in the middle of care and he had to wait."

The January 12, 2016 Resident Council Minutes document "Most of this group still feel there is a need to get the cell phone use under control."

The December 9, 2015 Resident Council Minutes document "Cell phones are still being used in the dining area".

On 6/15/16 at 3:45 pm Director of Nurse's (DON) E3 stated she has been the DON since March 2016. E3 stated " Our cell phone policy says the phones need to be locked up and not on their person during work." E3 stated "If we see staff using cell phones during work time we write them up." E3 stated the biggest problem is on the PM (afternoon/nights) shift. E3 stated cell phone

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usage has been a big problem and they are reminding new hires of our no cell phone use policy.

On 6/16/16 at 12:30 pm Administrator E1 stated she is still in the process of investigating R13's allegation (of E7 using a cell phone and possibly smoking while caring for R13). E1 stated she has not yet interviewed CNA E7.

The undated Employee Personal Call and Cell Phone Usage Policy states "Purpose: To establish a personal call and cell phone policy designed to create a productive workplace, minimizes distractions and provide excellent quality care...This applies to all employees...The policy mandates the following: A. Employees are to limit personal calls to necessary/emergency calls only; Employees are to recieve and make emergency calls from company phones only.The use of cellular phones is prohibited during work hours; Cellular phones are to kept, turned off, in the employee's purse or car."
Section 5 Enforcement outlined disciplinary action which included "First offense-Verbal Warning (cell phone locked up until end of shift)..Second offense-Written Warning (cell phone locked up until end of shift..Third offense-2 day Suspension (cell phone locked up until end of shift.. Fourth offense-Termination."

On 6/16/16 at 3:35 pm Assistant Director of Nursing (ADON) E4 confirmed that none of the staff should be carrying a cell phone with them while working. E4 stated all the staff have had the policy read to them during orientation and have had additional inservices when it has come up in resident council. E4 stated she has verbally counselled staff members who were using cell

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F 241	Continued From page 17 phones but E4 has not personally confiscated any staff cell phones as directed in the facility cell phone policy.	F 241		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to prevent cross contamination during incontinence care for one of five residents (R4) reviewed for incontinence in the sample of 15. Findings include: R4's Physician Order Sheet dated June 2016 documents the following diagnoses: Quadriplegia, Microcephally, Intra - Abdominal and Pelvic Swelling Mass and Lump, Gastrostomy Status, Pain, Pressure Ulcer Unspecified Buttock Stage III and Severe Intellectual Disability. R4's Minimum Data Set (MDS) dated 3/8/16	F 315		

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documents R4 as severe cognitively impaired and totally dependent on staff for incontinence care.

R4's Plan of Care dated 5/26/16 documents the following: "Provide incontinence care after each incontinent episode. Will be kept clean and dry."

R4's Progress Note dated 4/9/16 at 6:57 pm documents that the Nurse Practitioner was notified of R4's "thick, white, milky urine and reddened and irritated periarea with thick discharge. Order received to start Levaquin (antibiotic), 500 milligrams via G- Tube (Gastrostomy Tube), daily for seven days and Diflucan 200 milligrams per G-Tube daily for three days."

On 6/15/16 at 9:37 am E15, Certified Nursing Assistant provided incontinence care for R4. R4 was incontinent of bowel and bladder. E15 positioned R4 on R4's left side lying position and provided posterior perineal care. R4 was soiled with loose, dark green feces. E15 wiped R4 with a wash cloth from the top of the buttock crease to the perineum. The back to front motion moved loose feces over R4's anterior perineum area. E15 repositioned R4 to a back lying position and performed anterior perineal care. E15 cleaned R4 with back to front strokes. There was feces on the wash cloth as E15 wiped from the perineum over the labia and meatus.

On 6/15/16 at 9:50 am, E15 stated "I know to go from front to back not back to front. I guess I'm just nervous. I should have done the front pericare then repeated the back pericare, moving from front to back to prevent infection..."

The facility policy " Perineal Care" dated October

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F 315	Continued From page 19 2010 documents the following: "The purpose of this procedure is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition...Wash perineal area, wiping from front to back."	F 315		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide an effective means of maintaining hot food temperatures for resident room trays. This has the potential to affect two residents (R2,R20) in the sample reviewed for nutrition in the sample of 19 and nine residents (R17, R30-R35, R44, R50, R54) in the supplemental sample. The findings include: The Resident Council Minutes dated April 12, 2016 state "Over Easy Eggs always cold." On 6/15/16 at 9:30 am residents in the Group Meeting (R30-R35) stated that the food is not always hot. R20 stated that the eggs are always cold when R20 receives a breakfast room tray. R20 states the plate comes with an insulated cover but the food is still cold.	F 364		

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On 6/15/16 at 3:30 pm R2 stated that most the time the food is warm in the dining room, however a couple of days when R2 ate breakfast in her room the eggs were cold."

On 6/16/16 at 8:30 am R54 stated "I eat dinner and supper in my room and the food doesn't always stay hot." R54 stated she eats breakfast in the dining room and the eggs are hot there.

On 6/16/16 at 7:45 am breakfast was being served in the dining room. The steamtable was in the dining room. There were scrambled eggs, fried eggs, and hot cereal on the steamtable. Pasteurized shell eggs were being fried to order. The temperature of the scrambled eggs on the line were 157 degrees F, The fried eggs were 140 degrees F. and the hot cereal was 160 degrees F. At 7:50 am room trays were prepared for three residents R17, R44, and R50. At 8:00 am test tray was prepared per surveyor request. The hot food was placed on an unheated plastic plate. The plate was placed inside an insulated plate cover that had a base and a domed cover. There was no heated insert placed beneath the plate. The hot cereal was placed in a plastic bowl with a piece of clear plastic wrap over the top and was placed directly on the tray. The test tray remained unopened for 15 minutes while the staff delivered the other resident room trays.

On 6/16/16 at 8:15 am the temperature of the food on the Test Tray was measured and the food was tasted. The scrambled eggs were barely warm and measured 102 degrees Fahrenheit (F.), The fried egg tasted luke warm and was 107 degrees F. The Wheat and White toast was soggy and was barely warm.

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F 364	Continued From page 21 E10, Dietary Supervisor stated on 6/16/16 at 9:00 am stated that food temperatures are taken when the food comes out of the oven and when it is placed on the steam table. They also check the food on the line before preparing room trays. E10 stated she has not doing test trays to check the food holding temperatures of the room trays. E10 stated that the dietary staff pass the room trays for the residents on the West Wing and the Certified Nurse Aides pass the trays for residents on the East Wing which may make a difference in the length of time the food is held in the insulated plate units. E10 stated the facility has a plate warmer in the kitchen but it does not work. E10 stated she would love to have the plate warmer work.	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to label potentially hazardous food items with the date opened and use-by date to avoid potential foodborne illness and also failed to maintain sanitary food storage	F 371		

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F 371	Continued From page 22 conditions to avoid potential cross-contamination and foodborne illness. These failures have the potential to affect all 64 residents residing in the facility. Findings Include: On 6/15/2016 at 11:05 AM, the kitchen walk-in cooler contained one opened five pound container of cottage cheese, one opened five pound brick of cream cheese, and one opened gallon of milk. None of the food items were labeled with the date opened or the use-by date. The walk in cooler food storage racks were soiled throughout the cooler, were damp, and had an accumulation of dust and food debris. The cooler's metal wire fan guard was also soiled with all portions of the guard damp and covered in debris. One food storage rack of uncovered lettuce salads was located directly in front of where the fan was blowing in the cooler. On 6/15/2016 at 11:40 AM, E10 (Dietary Director) acknowledged the facility usually doesn't date opened milk because the facility goes through it so fast and that the cottage cheese and cream cheese should be dated with the date opened and the use-by date. E10 acknowledged the food storage racks and fan guard need cleaning. The Resident Census and Conditions of Residents report dated 6/14/2016 documents 64 residents residing in the facility.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		

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F 431	Continued From page 23 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to ensure that controlled medication labels, accounting and reconciliation of controlled drugs were in accordance with facility controlled drug policy.	F 431		

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F 431	Continued From page 24 These failures affected one of three residents (R22) reviewed for liquid morphine administration on the sample of 15. Findings include: On 6/14/16 at 1:00 pm E13, Licensed Practical Nurse, administered R22's Morphine 100 mg/ml (milliliter), 0.1 ml. E13 went to record the dose given and the remainder of Morphine in the bottle on the "Controlled Drug Record, Individual Patient's Narcotic Record" sheet. E13 did not measure the remainder and documented 8.0 ml and put a question mark after the entry. E13 stated "we just eyeball the bottle." The Patient's Narcotic Record sheet documented the previous administration remainder as 12.3 ml (123 doses). R22's "Controlled Drug Record, Individual Patient's Narcotic Record" sheet, has a label that does not document the name of the Physician, Prescription number, issuing pharmacy, date and time received, time to be administered, method of administration or the signature of person receiving medication. On 6/14/16, immediately after E13 administered the liquid Morphine to R22, E3, Director of Nursing (DON) and E4, Assistant DON re-measured the Morphine, using a syringe. There were two bottles of R22's Morphine opened and measured. The first bottle was the bottle E13 had just used to administer R22's liquid Morphine at 1:00 pm. Bottle number one was measured as 7.3 ml. The Narcotic Flow Sheet documents this bottle number one should contain 12.3 ml. Bottle number one is 5.0 ml short. Bottle number two should contain 10 ml. as recorded on the narcotic	F 431		

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record sheet. Bottle number two was also measured as 7.3 ml. Bottle number two is short 2.7 ml. R22's "Controlled Drug Record, Individual Patient's Narcotic Record" sheet also documented an entry correction of the Morphine count on 6/12/16 as a shortage of an additional 1.3 ml (13 doses) and on 6/13/16 an entry count correction of 4.2 ml (42 doses) shortage. The total Morphine missing, after review of the Medication Administration Record and the Narcotic Record sheets, totaled 13.2 ml (132 doses) from 6/12/16 to 6/14/16. These 13.2 ml were confirmed by E3, DON and E4, ADON when they measured the quantity of R22's liquid Morphine.

On 6/15/15 at 11:00 am E4, ADON stated "It is an error in counting, eyeballing the (R22's) morphine instead of using the syringe..."

On 6/16/16 at 12:03 pm E1, Administrator, stated " On 6/14/16, I was made aware of the discrepancy of the narcotic count sheet for (R22's) Morphine. At that time the DON (E3), ADON (E4) and (E18) the Corporate Nurse began investigating to reconcile the count and correct the documentation..."

On 6/17/16 at 9:50 am Z1, Pharmacist stated "The facility is responsible in labeling the narcotic sheet with all the information required by state and federal regulations. We do provide the label with all the information when we dispense a controlled substance and count sheet. When an outside pharmacy dispenses, the facility is responsible to complete all labeling on the narcotic count sheet. We will provide a blank sheet for the facility to fill in the blanks when an outside pharmacy has been used. The facility

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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 431	Continued From page 26 nurses count and maintain accuracy..." The facility policy "Controlled Substances" dated December 2012 documents the following: "...Controlled Substances must be counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals must sign the designated control substance record. If the count is correct, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance. Do not enter more than one prescription per page. This record must contain: a. Name of resident. b. Name and strength of the medication. c. Quantity received. d. Number on hand. e. Name of Physician. f. Prescription number. g. Name of issuing pharmacy. h. Date and time received. i. Time of administration. j. Method of administration. k. Signature of person receiving medication. l. Signature of nurse administering medication. The nursing staff must count controlled medication at the end of each shift. The nurse coming on and the nurse going off must make the count together. They must document and report any discrepancies to the Director of Nursing Services..."	F 431		