STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145519	A. BUILDING ______ B. WING ______	12/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE HALL NURSING & REHAB CENTER	620 WEST BRIDGEPORT WHITE HALL, IL 62092

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F 501	Continued From page 11 .	F 501		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.686a) 300.1210a) 300.3240a) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must provide the necessary care	F9999		

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F9999	Continued From page 12 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 assessment and plan of care. 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 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on record review and interviews the facility failed to ensure that 1(R5) of 3 residents on sample receiving anticoagulant therapy, had adequate monitoring, assessment, and interventions. The facility failed to have labs drawn as ordered and failed to respond appropriately when adverse consequences presented, indicating an excessive dose of anticoagulant medication. This failure resulted in R5 being sent to the hospital with a Protime (PT) of 129 (normal 11.0-13.0), an International Normalized Ratio (INR) of 74.60 HC (normal 2.00-3.00), and a severely bruised arm. R5 was hospitalized and received treatment for an elevated PT/INR among other diagnoses. Findings include: Review of R5's August, September, October and November 2009 Physician Order Sheets (POS), indicates she received Coumadin, 6 milligrams	F9999		

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F9999	Continued From page 13 daily, starting 8/3/09. Nurses notes of 10/28/09 indicate, in part, "A hematoma developed on the back of resident's left hand from the lab's venipuncture...(Z1, Physician) notified and order received...compression dressing was applied...circulation checks of fingers have been done regularly...skin color of fingers is good...fingers are warm to touch...." Nurses notes of 10/29/09 indicate: 2:15 A.M. " T (Temperature) 101.8 gave Tylenol 500 mg....resident had a small pool of blood on her pillow and had blood coming from left lower jaw...had a few blood clots in her mouth we got her all cleaned out the best that we could I elevated here hob (head of bed) could not get her to open enough to see exactly where the blood was coming from fax (Z1) of her condition." 1:21 P.M "...no more episodes of bleeding...(Z1) has not returned phone call at this time...1:47 P.M. Spoke with (Z1) regarding hematoma to residents left hand...is more swollen since breakfast. Area is warm to touch-black in color down the thumb-whole back of hand et part of thumb warm to touch. Orders rec'd to hold coumadin today and have a PT/INR drawn in the A.M." 11:41 P.M. "...had a large hematoma on her left hand that had been wrapped in a disposable elastic wrap yesterday...(R5) was sent to the local area hospital at 5:20 P.M. after Z3 (family) came to the facility, saw R5's arm, was upset and wanted R5 to be seen by Z1 at the hospital at which time she was admitted as an acute admission...PT/INR were very abnormal." Z1 was not notified of R5 having a small pool of	F9999		

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F9999	Continued From page 14	F9999		

blood and blood clots from her mouth, 10/29/09 2:15 A.M. until 1:47 P.M. (greater than 11 hours after R5 presented with symptoms).

According to the hospital laboratory results dated 10/29/09 R5's Protime was 129 (normal 11.0-13.0), and International Normalized Ratio (INR) 74.60 (normal 2.00-3.00). These levels were verified three times.

According to the hospital Discharge Summary, R5 was given Aquamephyton and Coumadin was stopped. She was also found to be very anemic with a hemoglobin and hematocrit ranging in the amount of 8.6 and 25.1 respectively (normal 11.8-14.3 and 24-45). She was given 2 units of blood and was taken off Coumadin and put on aspirin since she had the same problem in the past (elevated PT/INR).

A review of previous laboratory results show that R5 had a PT of 27.2 and INR 4.1 on 10/1/09. A note on the lab results indicated it had been faxed to Z1. There is no documentation of a response from the physician. On 10/7/09, in Z1's Progress Notes he wrote, "meds and labs reviewed." He did not indicate specifically that he reviewed the elevated PT/INR.

In an interview with E2, Director of Nursing on 12/10/09 at 10:30 A.M., she stated that for Z1, he wants the lab results faxed to his office. His office staff lays them on his chair and he reviews them when he comes in the office next.

R5 was readmitted to the facility from the hospital on 11/07/09 at 5:00 P.M. Nurses notes indicate, in part, "is bruised from all fingertips to up to left elbow with a dark purple bruising...has some old

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F9999	Continued From page 15 greenish bruises on right forearm and post right hand. Interview with E2, and she confirms that Z1 was not notified of R5's signs and symptoms of the possibility of having too much Coumadin accumulated in her blood from the time nurse first noted this on 10/29/09 at 2:15 A.M. until 1:47 P.M. (about 11 1/2 hours later), and that R5's physician orders for PT/INR orders to draw every three weeks were not followed. Interview with E1, Administrator indicates that none of the nurses involved with R5's medical issue with her left arm being black, blue and swollen remember any other times other than the computer time stamp as to when documentation occurred, nor when the actual event occurred. (A)	F9999		