		AND HUMAN SERVICES					APPROVED	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OI	MB NO.	0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA   AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						(X3) DATE SURVEY COMPLETED		
		145517	B. WING _			C 03/25/2016		
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE C	OAK REHABILITATION	I & HCC			700 WHITE STREET IOUNT VERNON, IL 62864			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	S	F 0	00				
	Complaint #165128	80/IL83912 - F282, F329						
	Complaint #165151 F329, F514	1/IL84180 - F280, F282,						
F 280 SS=D		0(k)(2) RIGHT TO NNING CARE-REVISE CP	F 2	:80				
	incompetent or othe incapacitated under	r the laws of the State, to ng care and treatment or						
	within 7 days after t comprehensive ass interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resi legal representative	are plan must be developed he completion of the essment; prepared by an m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after						
	by: Based on record re failed to address or of Deep Vein Thron	NT is not met as evidenced eview and interview, the facility the Care Plan new diagnoses abosis and Urinary Tract (R4) residents reviewed for ample of 4.						

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

TITLE

(X6) DATE

PRINTED: 03/30/2016

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES     STATEMENT OF DEFICIENCIES   (X1) PROVIDER/SUPPLIER/CLIA     AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		145517	B. WING				_ 25/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE OAK REHABILITATION & HCC					700 WHITE STREET NOUNT VERNON, IL 62864		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 280	Continued From pa	ne 1	F 2	80			
. 200	The findings are:		1 2	00			
		Id resident with discusses that					
		Id resident with diagnoses that Dementia as noted on the					
		ian Order Sheet (POS) and Vein Thrombosis (DVT) and					
	Urinary Tract Infect	ion (UTI) as noted on the					
		History and Physical. Nurses 6 with no time documented					
	indicates that R4 re	turned to the facility. A					
		n Nurses Note documents that arted as ordered. A hospital					
	"Patient After Visit S	Summary" dated 3-19-2016					
		harge Medication List" and is to start taking Bactrim					
	800-160 mg twice c	aily for 5 days and Coumadin					
		aily and to watch "INR alization Ratio) closely." The					
		Physical dated 3-18-2016 diagnosed with a Urinary Tract					
		p Vein Thrombosis. As of					
		re Plan (Quarterly update of been updated to include the					
	new problem areas	of DVT and UTI. This was					
	verified with E2, Dir at 11:15 am.	ector of Nurses on 3-25-2016					
F 282	483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	F 2	82			
SS=D	PERSONS/PER CA	ARE PLAN					
		led or arranged by the facility					
		y qualified persons in ch resident's written plan of					
	care.						
		NT is not met as evidenced					
	by: Based on record re	eview and interview, the facility					
		· · ·					

Facility ID: IL6004881

If continuation sheet Page 2 of 12

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION G		E SURVEY PLETED
	145517		A. DOILD	ii ve	G		C
		145517	B. WING				
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	AK REHABILITATION	I & HCC			1700 WHITE STREET		
					MOUNT VERNON, IL 62864		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
F 000							
F 282	Continued From pa	•	F 2	282	2		
		sician orders to obtain aws for Prothrombin Time and					
		alization Ratio (PT/INR) for 3					
	of 3 (R2, R3, R4) re	esidents reviewed for warfarin					
	use in the sample o	of 4.					
	The findings are:						
	-						
		old resident with diagnoses ner's Dementia as noted on					
		hysician Order Sheet (POS)					
	and diagnoses of D	eep Vein Thrombosis (DVT)					
		fection (UTI) as noted on the					
	3-18-2016 Hospital	History and Physical.					
	A hospital "Patient A	After Visit Summary" dated					
		urrent Discharge Medication					
		s that R4 is to start taking ms (mg) subcutaneous every					
	twelve hours and	ins (ing) subcutaneous every					
		riamethoprim 800-160 mg					
		5 days (generic for Bactrim)					
		generic for Coumadin) every 9-2016. The order specifically					
		closely as Bactrim can					
		eatly and patient may require					
	lower doses of warf	arin" An "Addendum" to a					
		Summary with a date of					
	days and until INR :	Will order daily INR's for 7					
		acility on 3-19-2016 as noted					
		s for 3-19-2016 (no time					
		f 3-24-2016 at 2:45 pm, no aws or reports for INR levels					
		a result, R4 did not have the					
		els checked for 4 days. E2					
	(Director of Nurses)	) verified at 2:50 pm on					
	3-24-2016 that the	facility had not arranged to					

Facility ID: IL6004881

If continuation sheet Page 3 of 12

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION (X3) DATE S				
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY PLETED
_			A. BUILD	ING	·		
		145517	B. WING			C 03/25/2	
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	AK REHABILITATION			1	1700 WHITE STREET		
				N	MOUNT VERNON, IL 62864		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
TAG			IAG		DEFICIENCY)	10/ (1 <b>E</b>	
			l I				
F 282	Continued From pa	ae 3	F 2	82			
		r the INR levels. E2 stated that		.02			
		en corrected and R4's INR					
		vn "this evening." On					
	3-25-2016 at 9:00 a	am, a lab report for R4's					
		noted in the record. The INR					
		ntly lower than 2.0-3.0					
	recommended whe						
	prophylaxis of Thro	MDOSIS.					
	B4's March 2016 P	OS included an order dated					
		ipro 500mg, one by mouth					
		ays. As noted above, R4 was					
		pital on 3-18-2016 and					
		016. The 3-19-2016 "Current					
		on List" documents the					
		king these medications" and					
		cin 500 mg tablet (commonly					
		The March 2016 Medication ord was reviewed on					
		umentation showed that the					
		as still being administered to					
		Director of Nurses) verified on					
		om that the Cipro was still					
	being administered	and was not supposed to be.					
		old resident with diagnoses					
		ibrillation as noted on a ders for Receiving Facility"					
		he February 2016 Physician					
		includes an order for					
		n). A lab report dated					
		at R3 has a critical high range					
		b draw and notes that the					
		ed and ordered the Coumadin					
		her notice. The February 2016					
		its this order as a telephone					
		udes orders to repeat the PT/ 016. The 2-26-2016 lab					
		evel to still be "critical high" at					

Facility ID: IL6004881

If continuation sheet Page 4 of 12

		-	AND HUMAN SERVICES				FORM	: 03/30/2016 APPROVED . 0938-0391
Ī	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
			145517	B. WING				C / <b>25/2016</b>
I	NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	WHITE O	OAK REHABILITATION	1 & HCC			1700 WHITE STREET MOUNT VERNON, IL 62864		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	F 282	mouth "now" and to on 2-27-16. The red documentation of th results of one for 2- the following day or the INR noted to be includes an order d PT/INR on 3-24-20 3-21-2016 indiates the therapeutic rang The record did not obtained as ordered verified on 3-25-20 ordered PT/INR lab either 2-26-2016 or PT/INR would be du and reported to the 3. R2 is an 85 year of Deep Vein Thron 2016 POS. A Janua order dated 1-4-20 and recheck PT/INI lab report dated for INR levels to both b The record did not re-drawn on 1-7-20 level was drawn on was noted as 1.37. notes R2's PT level 5.7 high. An order t recheck the PT/INF received that same level was found for was drawn on 2-13 as 3.05. E3 verified that the labs had no	n order for Vitamin K 2.5 mg by b repeat the PT/INR level again cord did not include he lab being drawn nor the -27-2016. The lab was drawn in 2-28-2016 with the results of a 1.53. The March 2016 POS lated 3-21-2016 to repeat a 16. A lab report dated that R3's INR level is below ge for prevention of embolus. reflect that the PT/INR lab was d. E2 (Director of Nurses) 16 at 11:15 am that the bs had not been obtained on r 3-24-2016. E2 stated that the rawn that evening (3-25-2016)	F 2	282			

Facility ID: IL6004881

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED C		
		145517	B. WING			03/25/2016		
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 700 WHITE STREET			
WHITE C	DAK REHABILITATION	I & HCC			IOUNT VERNON, IL 62864			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329 SS=D		EGIMEN IS FREE FROM RUGS	F 3	329				
	unnecessary drugs. drug when used in a duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent contraindicated, in a drugs. This REQUIREMEN by: Based on interview failed to ensure tha anticoagulant media for adverse conseq Prothrombin Time a Ratio as is required	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above. Thensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these NT is not met as evidenced and record review, the facility t residents receiving the cation warfarin were monitored uences by blood draws for and International Normalization for 3 of 3 (R2, R3, R4) for warfarin use in the sample						

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PRINTED: 03/30/2016

	FORM	APPROVED						
					LE CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	à	COMPLETED		
		145517	B. WING			C 03/25/2016		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WHITE OAK REHABILITATION & HCC					1700 WHITE STREET MOUNT VERNON, IL 62864			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIC		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE	
F 329	Continued From pa	ae 6	F3	329				
	The findings are:	900		20				
	1 B4 is a 66 year o	ld resident with diagnoses that						
	include Alzheimer's	Dementia as noted on the						
		ian Order Sheet (POS) and Vein Thrombosis (DVT) and						
	Urinary Tract Infect	ion (UTI) as noted on the						
	3-18-2016 Hospital	History and Physical.						
		dated 3-17-2016 at 11:30 am een by Z1 (Nurse Practioner)						
	and an order was re	eceived that included a						
		udy to right lower leg. The ncludes orders written by Z1						
	for the Venous Dop	pler study to right lower						
	extremity for edema Electrocardiogram	a and pain, an (EKG) for tachycardia.						
		ment on 3-18-2016 at 1:00 pm						
		der from Z2 (Medical Doctor) nd R4 to the emergency room						
	related to an abnor	mal EKG reading.						
		9:30 pm indicates that R4 was ration due to an abnormal						
	EKG, weakness an	d UTI. Nurses Notes for						
		ime documented indicates the facility. At 10:00 pm,						
		ment that an antibiotic was						
		After Visit Summary" dated Surrent Discharge Medication						
	List" and document	s that R4 is to start taking						
	Lovenox 40 milligra twelve hours and	ms (mg) subcutaneous every						
	Sulfamethoxazole-t	riamethoprim 800-160 mg two						
		ys (generic for Bactrim) and eric for Coumadin) every						
		19-2016. The order specifically						

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		AND HUMAN SERVICES				FORM	03/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		145517	B. WING	i			C 25/2016
NAME OF	PROVIDER OR SUPPLIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
WHITE C	OAK REHABILITATION	N & HCC			700 WHITE STREET MOUNT VERNON, IL 62864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	increase the INR gr lower doses of warf hospital Discharge 3-19-2016 states, " days and until INR R4 returned to the f in the Nurses Notes documented). As o record of any lab dr could be found. E2 3-24-2016 that the have labs drawn fo R4 did not have the checked for 4 days had been corrected drawn "this evening lab report for R4's F record. The INR res 2.0-3.0 recommend prophylaxis of Thro 2. R3 is an 84 year that include Atrial F hospital "Patient Or dated 3/20/2016. T Order Sheet (POS) Coumadin (warfarir 2-25-2016 notes th for a PT (60.9) and that the physician w Coumadin to be he February 2016 POS telephone order am- repeat the PT/ INR 2-26-2016 lab indic	closely as Bactrim can reatly and patient may require farin" An "Addendum" to a Summary with a date of Will order daily INR's for 7 >2." facility on 3-19-2016 as noted is for 3-19-2016 (no time f 3-24-2016 at 2:45 pm, no raws or reports for INR levels verified at 2:50 pm on facility had not arranged to r the INR levels. As a result, e ordered PT/INR levels . E2 stated that the problem I and R4's INR level would be g." On 3-25-2016 at 9:00 am, a PT/INR levels was noted in the sult was 1.5, slightly lower than ded when on Coumadin for	F	329			

Facility ID: IL6004881

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		AND HUMAN SERVICES				FORM	03/30/2016 APPROVED
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	0938-0391 E SURVEY PLETED
		145517	B. WING				C 25/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	DAK REHABILITATION	1 & HCC			700 WHITE STREET IOUNT VERNON, IL 62864		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	Vitamin K 2.5 mg b the PT/INR level ag did not include docu drawn nor the resul lab was drawn the f with the results of th March 2016 POS in 3-21-2016 to repea lab report dated 3-2 level is below the th of embolus. The rea PT-INR lab was obt 3-24-2016. E2 (Dire 3-25-2016 at 11:15 labs had not been c or 3-24-2016. E2 st drawn that evening the physician. 3. R2 is an 85 year of Deep Vein Thron 2016 POS. A Janua order dated 1-4-20 and recheck PT/INI lab report dated for INR levels to both b The record did not drawn as ordered notes R2's PT level as 5.7 (high). An or and to recheck the received that same level was found for was drawn on 2-13 as 3.05. E3 verified that the labs had not	age 8 by mouth "now" and to repeat gain on 2-27-16. The record umentation of the lab being lts of one for 2-27-2016. The following day on 2-28-2016 he INR noted to be 1.53. The ncludes an order dated at a PT/INR on 3-24-2016. A 21-2016 indiates that R3's INR herapeutic range for prevention cord did not reflect that the tained as ordered on ector of Nurses) verified on am that the ordered PT/INR obtained for either 2-26-2016 tated that the PT/INR would be (3-25-2016) and reported to old resident with a diagnosis nbosis as noted on the March ary 2016 POS includes an 16 to hold Coumadin x 3 days R "on Thursday" (1-7-2016). A 1-4-2016 noted the PT and be high (PT 54.5 and INR 5.5). indicate that the lab was A lab report dated 2-11-2016 I as 56.2 (high) and INR level der to hold R2's Coumadin PT/INR level in "the am" was e day. No record of the PT/INR 2-12-2016. The PT/INR level -2016 and the INR was noted d on 3-25-2016 at 10:05 am of been obtained as ordered 2016 or 2-12-2016 dates.	F 3	,29			

Facility ID: IL6004881

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		AND HUMAN SERVICES				FOI	ED: 03/30/2016 RM APPROVED IO. 0938-0391	
STATEMEN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		145517	B. WING	i			03/25/2016	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO			
WHITE C	DAK REHABILITATION	N & HCC			1700 WHITE STREET MOUNT VERNON, IL 62864			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514 F 514 SS=D	483.75(I)(1) RES RECORDS-COMP LE The facility must m resident in accorda standards and prace accurately docume systematically orga The clinical record information to ident resident's assessm services provided; preadmission scree and progress notes This REQUIREMEN by: Based on record re failed to ensure tha contain complete a resident status and (R4) residents revie significant change in The findings are: 1. R4 is a 66 year of include Alzheimer's March 2016 Physic diagnoses of Deep Urinary Tract Infect 3-18-2016 Hospital Nurses notes (NN) note that R4 was se	LETE/ACCURATE/ACCESSIB aintain clinical records on each ince with accepted professional ctices that are complete; nted; readily accessible; and inized. must contain sufficient tify the resident; a record of the tents; the plan of care and the results of any ening conducted by the State; s. NT is not met as evidenced eview and interview, the facility it resident clinical records nd accurate documentation of condition change for 1 of 4 ewed for resident status and	F	514				

Facility ID: IL6004881

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/30/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		145517	B. WING				C 25/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK REHABILITATION	I & HCC			700 WHITE STREET IOUNT VERNON, IL 62864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	X-ray, and EKG (E Nurses Notes docu 3-17-2016 entry as contain no docume condition prior to th 2016 POS includes Venous Doppler stu edema and pain, ar tachycardia, and Ci 10 days for lower re "24 hour Nursing R R4 as having an ax to "please have Z1 at right leg." E2 (Din 3-25-2016 at 11:15 Report" is not part of used at shift chang of resident changes Hour Nursing Repo that R4 had a HR (I "is aware" and that The information on indicates changes if documentation in th status changes for The Nurses Notes for The Nurses Notes for The Nurses Notes for Nital signs and "will nothing else. A 3-19 documents that R4 an antibiotic was s documentation in th 3-20-2016 at 10:00 signs and reference	dy to right lower leg, Chest lectrocardiogram). The ment the last entry prior to this 2-26-2016. The Nurses notes intation of a change in R4's e 3-17-2016 entry. The March orders written by Z1 for the udy to right lower extremity for n Electrocardiogram (EKG) for pro 500 mg 1 twice daily for espiratory infection. A facility eport" dated 3-16-2016 lists illary temperature of 99.1 and (Nurse Practioner) take a look rector of Nurses) verified on am that this 24 Hour Nursing of the clinical record but is e to notify the oncoming nurse s and new information. A 24 rt dated 3-17-2016 documents neart rate) of 140 and that Z1 there were new orders for R4. this 24 Hour Nursing Report n R4's status but there is no ne clinical record of these R4.	F 5	;14			

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		AND HUMAN SERVICES				FORM	03/30/2016 APPROVED 0938-0391
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED C
		145517	B. WING				25/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	DAK REHABILITATION	N & HCC			700 WHITE STREET IOUNT VERNON, IL 62864		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 514	returning with a dia R4 returning on Lov Coumadin therapy 3-24-2016 at 2:00 p been updated since entry. E3 (Assistan on 3-25-2016 at 10 record did not inclu change in status th received on 3-17-2 had failed to docum	gnosis of DVT or UTI, or of venox injections and for the DVT diagnosis. As of om, the Nurses Notes had not e the 3-20-2016 10:00 am t Director of Nurses) verified :05 am that R4's clinical de documentation of R4's at resulted in the orders 016 from Z1 and that nurses nent complete and accurate onitoring of R4, after her	F 5	514			

Facility ID: IL6004881

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