STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. BUILDING _____ B. WING _____	C 03/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK REHABILITATION & HCC	**1700 WHITE STREET MOUNT VERNON, IL 62864**

(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 Complaint #1651280/IL83912 - F282, F329 Complaint #1651511/IL84180 - F280, F282, F329, F514	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to address on the Care Plan new diagnoses of Deep Vein Thrombosis and Urinary Tract Infection for 1 of 3 (R4) residents reviewed for Care Plans in the sample of 4.	F 280		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 1 The findings are: 1. R4 is a 66 year old resident with diagnoses that include Alzheimer's Dementia as noted on the March 2016 Physician Order Sheet (POS) and diagnoses of Deep Vein Thrombosis (DVT) and Urinary Tract Infection (UTI) as noted on the 3-18-2016 Hospital History and Physical. Nurses Notes for 3-19-2016 with no time documented indicates that R4 returned to the facility. A 3-19-2016 10:00 pm Nurses Note documents that an antibiotic was started as ordered. A hospital "Patient After Visit Summary" dated 3-19-2016 notes "Current Discharge Medication List" and documents that R4 is to start taking Bactrim 800-160 mg twice daily for 5 days and Coumadin 5 milligrams (mg) daily and to watch "INR (International Normalization Ratio) closely." The hospital History and Physical dated 3-18-2016 notes that R4 was diagnosed with a Urinary Tract Infection and a Deep Vein Thrombosis. As of 3-25-2016, R4's Care Plan (Quarterly update of 3-2-2016) had not been updated to include the new problem areas of DVT and UTI. This was verified with E2, Director of Nurses on 3-25-2016 at 11:15 am.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 282		

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F 282	Continued From page 2	F 282		

failed to follow physician orders to obtain laboratory blood draws for Prothrombin Time and International Normalization Ratio (PT/INR) for 3 of 3 (R2, R3, R4) residents reviewed for warfarin use in the sample of 4.

The findings are:

1. R4 is a 66 year old resident with diagnoses that include Alzheimer's Dementia as noted on the March 2016 Physician Order Sheet (POS) and diagnoses of Deep Vein Thrombosis (DVT) and Urinary Tract Infection (UTI) as noted on the 3-18-2016 Hospital History and Physical.

A hospital "Patient After Visit Summary" dated 3-19-2016 notes "Current Discharge Medication List" and documents that R4 is to start taking Lovenox 40 milligrams (mg) subcutaneous every twelve hours and Sulfamethoxazole-triamethoprim 800-160 mg two times daily for 5 days (generic for Bactrim) and warfarin 5 mg (generic for Coumadin) every evening starting 3-19-2016. The order specifically states, "Watch INR closely as Bactrim can increase the INR greatly and patient may require lower doses of warfarin..." An "Addendum" to a hospital Discharge Summary with a date of 3-19-2016 states, "Will order daily INR's for 7 days and until INR >2."

R4 returned to the facility on 3-19-2016 as noted in the Nurses Notes for 3-19-2016 (no time documented). As of 3-24-2016 at 2:45 pm, no record of any lab draws or reports for INR levels could be found. As a result, R4 did not have the ordered PT/INR levels checked for 4 days. E2 (Director of Nurses) verified at 2:50 pm on 3-24-2016 that the facility had not arranged to

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F 282	Continued From page 3	F 282		

have labs drawn for the INR levels. E2 stated that the problem had been corrected and R4's INR level would be drawn "this evening." On 3-25-2016 at 9:00 am, a lab report for R4's PT/INR levels was noted in the record. The INR result was 1.5, slightly lower than 2.0-3.0 recommended when on Coumadin for prophylaxis of Thrombosis.

R4's March 2016 POS included an order dated for 3-17-2016 for Cipro 500mg, one by mouth twice daily for 10 days. As noted above, R4 was admitted to the hospital on 3-18-2016 and returned on 3-19-2016. The 3-19-2016 "Current Discharge Medication List" documents the following: "Stop taking these medications" and includes "ciprofloxacin 500 mg tablet (commonly known as Cipro)." The March 2016 Medication Administration Record was reviewed on 3-25-2016 and documentation showed that the Cipro medication was still being administered to R4. E3 (Assistant Director of Nurses) verified on 3-25-2016 at 2:30 pm that the Cipro was still being administered and was not supposed to be.

2. R3 is an 84 year old resident with diagnoses that include Atrial Fibrillation as noted on a hospital "Patient Orders for Receiving Facility" dated 3/20/2016. The February 2016 Physician Order Sheet (POS) includes an order for Coumadin (warfarin). A lab report dated 2-25-2016 notes that R3 has a critical high range for a PT and INR lab draw and notes that the physician was notified and ordered the Coumadin to be held until further notice. The February 2016 POS also documents this order as a telephone order and also includes orders to repeat the PT/ INR level on 2-26-2016. The 2-26-2016 lab indicates the INR level to still be "critical high" at

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F 282	Continued From page 4 6.6 and includes an order for Vitamin K 2.5 mg by mouth "now" and to repeat the PT/INR level again on 2-27-16. The record did not include documentation of the lab being drawn nor the results of one for 2-27-2016. The lab was drawn the following day on 2-28-2016 with the results of the INR noted to be 1.53. The March 2016 POS includes an order dated 3-21-2016 to repeat a PT/INR on 3-24-2016. A lab report dated 3-21-2016 indiates that R3's INR level is below the therapeutic range for prevention of embolus. The record did not reflect that the PT/INR lab was obtained as ordered. E2 (Director of Nurses) verified on 3-25-2016 at 11:15 am that the ordered PT/INR labs had not been obtained on either 2-26-2016 or 3-24-2016. E2 stated that the PT/INR would be drawn that evening (3-25-2016) and reported to the physician. 3. R2 is an 85 year old resident with a diagnosis of Deep Vein Thrombosis as noted on the March 2016 POS. A January 2016 POS includes an order dated 1-4-2016 to hold Coumadin x 3 days and recheck PT/INR "on Thursday" (1-7-2016). A lab report dated for 1-4-2016 noted the PT and INR levels to both be high (PT 54.5 and INR 5.5). The record did not indicate that the lab was re-drawn on 1-7-2016 as ordered. The PT/INR level was drawn on 1-8-2016 and the INR level was noted as 1.37. A lab report dated 2-11-2016 notes R2's PT level as 56.2 high and INR level as 5.7 high. An order to hold R2's Coumadin and to recheck the PT/INR level in "the am" was received that same day. No record of the PT/INR level was found for 2-12-2016. The PT/INR level was drawn on 2-13-2016 and the INR was noted as 3.05. E3 verified on 3-25-2016 at 10:05 am that the labs had not been obtained as ordered on either the 1-7-2016 or 2-12-2016 dates.	F 282		

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F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents receiving the anticoagulant medication warfarin were monitored for adverse consequences by blood draws for Prothrombin Time and International Normalization Ratio as is required for 3 of 3 (R2, R3, R4) residents reviewed for warfarin use in the sample of 4.	F 329		

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F 329	Continued From page 6	F 329		

The findings are:

1. R4 is a 66 year old resident with diagnoses that include Alzheimer's Dementia as noted on the March 2016 Physician Order Sheet (POS) and diagnoses of Deep Vein Thrombosis (DVT) and Urinary Tract Infection (UTI) as noted on the 3-18-2016 Hospital History and Physical.

Nurses notes (NN) dated 3-17-2016 at 11:30 am note that R4 was seen by Z1 (Nurse Practioner) and an order was received that included a Venous Doppler study to right lower leg. The March 2016 POS includes orders written by Z1 for the Venous Doppler study to right lower extremity for edema and pain, an Electrocardiogram (EKG) for tachycardia.

Nurses Notes document on 3-18-2016 at 1:00 pm that a telephone order from Z2 (Medical Doctor) was received to send R4 to the emergency room related to an abnormal EKG reading. Documentation for 9:30 pm indicates that R4 was admitted for observation due to an abnormal EKG, weakness and UTI. Nurses Notes for 3-19-2016 with no time documented indicates that R4 returned to the facility. At 10:00 pm, Nurses Notes document that an antibiotic was started as ordered.

A hospital "Patient After Visit Summary" dated 3-19-2016 notes "Current Discharge Medication List" and documents that R4 is to start taking Lovenox 40 milligrams (mg) subcutaneous every twelve hours and Sulfamethoxazole-triamethoprim 800-160 mg two times daily for 5 days (generic for Bactrim) and warfarin 5 mg (generic for Coumadin) every evening starting 3-19-2016. The order specifically

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F 329	Continued From page 7	F 329		

states, "Watch INR closely as Bactrim can increase the INR greatly and patient may require lower doses of warfarin..." An "Addendum" to a hospital Discharge Summary with a date of 3-19-2016 states, "Will order daily INR's for 7 days and until INR >2."

R4 returned to the facility on 3-19-2016 as noted in the Nurses Notes for 3-19-2016 (no time documented). As of 3-24-2016 at 2:45 pm, no record of any lab draws or reports for INR levels could be found. E2 verified at 2:50 pm on 3-24-2016 that the facility had not arranged to have labs drawn for the INR levels. As a result, R4 did not have the ordered PT/INR levels checked for 4 days. E2 stated that the problem had been corrected and R4's INR level would be drawn "this evening." On 3-25-2016 at 9:00 am, a lab report for R4's PT/INR levels was noted in the record. The INR result was 1.5, slightly lower than 2.0-3.0 recommended when on Coumadin for prophylaxis of Thrombosis.

2. R3 is an 84 year old resident with diagnoses that include Atrial Fibrillation as noted on a hospital "Patient Orders for Receiving Facility" dated 3/20/2016. The February 2016 Physician Order Sheet (POS) includes an order for Coumadin (warfarin). A lab report dated 2-25-2016 notes that R3 has a critical high range for a PT (60.9) and INR (6.2) lab draw and notes that the physician was notified and ordered the Coumadin to be held until further notice. The February 2016 POS also documents this as a telephone order and also includes orders to repeat the PT/ INR level on 2-26-2016. The 2-26-2016 lab indicates the INR level to still be "critical high" at 6.6 and includes an order for

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F 329	Continued From page 8 Vitamin K 2.5 mg by mouth "now" and to repeat the PT/INR level again on 2-27-16. The record did not include documentation of the lab being drawn nor the results of one for 2-27-2016. The lab was drawn the following day on 2-28-2016 with the results of the INR noted to be 1.53. The March 2016 POS includes an order dated 3-21-2016 to repeat a PT/INR on 3-24-2016. A lab report dated 3-21-2016 indiates that R3's INR level is below the therapeutic range for prevention of embolus. The record did not reflect that the PT-INR lab was obtained as ordered on 3-24-2016. E2 (Director of Nurses) verified on 3-25-2016 at 11:15 am that the ordered PT/INR labs had not been obtained for either 2-26-2016 or 3-24-2016. E2 stated that the PT/INR would be drawn that evening (3-25-2016) and reported to the physician. 3. R2 is an 85 year old resident with a diagnosis of Deep Vein Thrombosis as noted on the March 2016 POS. A January 2016 POS includes an order dated 1-4-2016 to hold Coumadin x 3 days and recheck PT/INR "on Thursday" (1-7-2016). A lab report dated for 1-4-2016 noted the PT and INR levels to both be high (PT 54.5 and INR 5.5). The record did not indicate that the lab was drawn as ordered.. A lab report dated 2-11-2016 notes R2's PT level as 56.2 (high) and INR level as 5.7 (high). An order to hold R2's Coumadin and to recheck the PT/INR level in "the am" was received that same day. No record of the PT/INR level was found for 2-12-2016. The PT/INR level was drawn on 2-13-2016 and the INR was noted as 3.05. E3 verified on 3-25-2016 at 10:05 am that the labs had not been obtained as ordered on either the 1-7-2016 or 2-12-2016 dates.	F 329		

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F 514 F 514 SS=D	Continued From page 9 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that resident clinical records contain complete and accurate documentation of resident status and condition change for 1 of 4 (R4) residents reviewed for resident status and significant change in the sample of 4. The findings are: 1. R4 is a 66 year old resident with diagnoses that include Alzheimer's Dementia as noted on the March 2016 Physician Order Sheet (POS), and diagnoses of Deep Vein Thrombosis (DVT) and Urinary Tract Infection (UTI) as noted on the 3-18-2016 Hospital History and Physical. Nurses notes (NN) dated 3-17-2016 at 11:30 am note that R4 was seen by Z1 (Nurse Practioner) and an order was received that included a	F 514 F 514		

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Venous Doppler study to right lower leg, Chest X-ray, and EKG (Electrocardiogram). The Nurses Notes document the last entry prior to this 3-17-2016 entry as 2-26-2016. The Nurses notes contain no documentation of a change in R4's condition prior to the 3-17-2016 entry. The March 2016 POS includes orders written by Z1 for the Venous Doppler study to right lower extremity for edema and pain, an Electrocardiogram (EKG) for tachycardia, and Cipro 500 mg 1 twice daily for 10 days for lower respiratory infection. A facility "24 hour Nursing Report" dated 3-16-2016 lists R4 as having an axillary temperature of 99.1 and to "please have Z1 (Nurse Practioner) take a look at right leg." E2 (Director of Nurses) verified on 3-25-2016 at 11:15 am that this 24 Hour Nursing Report" is not part of the clinical record but is used at shift change to notify the oncoming nurse of resident changes and new information. A 24 Hour Nursing Report dated 3-17-2016 documents that R4 had a HR (heart rate) of 140 and that Z1 "is aware" and that there were new orders for R4. The information on this 24 Hour Nursing Report indicates changes in R4's status but there is no documentation in the clinical record of these status changes for R4.

The Nurses Notes for 3-19-2016 document that R4 returned to the facility from the hospital(there is no time of arrival documented in the record). This re-admission Nurses Note documents some vital signs and "will continue to monitor," but nothing else. A 3-19-2016 10:00 pm Nurse Note documents that R4 was resting quietly and that an antibiotic was started. The next documentation in the Nurses notes is for 3-20-2016 at 10:00 am. It includes a set of vital signs and references antibiotic therapy. None of this documentation includes any reference to R4

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F 514	Continued From page 11 returning with a diagnosis of DVT or UTI, or of R4 returning on Lovenox injections and Coumadin therapy for the DVT diagnosis. As of 3-24-2016 at 2:00 pm, the Nurses Notes had not been updated since the 3-20-2016 10:00 am entry. E3 (Assistant Director of Nurses) verified on 3-25-2016 at 10:05 am that R4's clinical record did not include documentation of R4's change in status that resulted in the orders received on 3-17-2016 from Z1 and that nurses had failed to document complete and accurate assessment and monitoring of R4, after her return from the hospital on 3-19-2016.	F 514		