STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. BUILDING _____ B. WING _____	**09/16/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide timely notification to the resident's representative and/or physician of significant changes in the resident condition, status of infection and/or treatment prescribed for infection, residents refusal of medications or medications not given as ordered by the prescribing physician for 2 of 2 residents (R3, R4) reviewed for timely resident representative and/or physician notification in the sample of 8. Findings include: 1.) R4's medical records shows R4 was admitted to this facility on 3/13/2020 and discharged on [DATE]. V11's, (Social Services Director/SSD), Social Service Progress Note documents that R4 was admitted from home for respite care, (short term care for caregiver relief). V11's note shows R4 was to receive PD, (Peritoneal [MEDICAL TREATMENT]), R4 was weak, needed to be hand fed, and was expected to be at the facility for a week or two. On 8/27/2020 at 12:45 PM, V11(SSD) said she did not remember making any calls to notify V8 of any changes in condition. V11 said usually the nursing staff would contact family and write a nurse's note documenting family notification. A Nurses' Note for R4, dated 3/30/2020 at 10:30am states V14, (Advanced Practice Registered Nurse/APRN), notified of resident having loose stools. New orders received. R4's physician's orders [REDACTED]. On 4-1-2020, R4's stool sample Lab Report showed R4 tested positive for [DIAGNOSES REDACTED] ([MEDICAL CONDITION]) bowel infection. On 4-1-2020, R4's physician's orders [REDACTED]. V8 (Family) said the first time she was aware of R4 being ordered antibiotics was after receiving an itemized bill from the nursing home that listed a charge for the antibiotics. V8 said she never was notified by the nursing home of R4's loose stools, bowel infection or of the antibiotics given to R4 to treat the bowel infection. V15 (Licensed Practical Nurse/Care Plan Coordinator) said on 3-30-2020, the facility did collect a stool sample from R4 for testing that showed R4 tested positive for [DIAGNOSES REDACTED] ([MEDICAL CONDITION]) bowel infection. V15 said R4's physician was notified and on 4-1-2020, R4 was started on [MEDICATION NAME] brand antibiotics as ordered. V15 said R4's MAR(Medication Administration Record) documents R4 received 7 doses of the [MEDICATION NAME] antibiotic while at the facility. V15 said it is the facility's policy to notify resident's families of any change in condition, any abnormal lab reports and any newly prescribed medications. V15 said she could not find any documented evidence of the facility notifying V8 (Family) of R4's loose stools, R4's bowel infection or of R4 receiving the prescribed antibiotics to treat the bowel infection. 2.) R3's clinical admission record indicates that she was admitted on [DATE] with a [DIAGNOSES REDACTED]. R3's Minimum Data Set (MDS) assessment dated [DATE] indicates that she has a Brief Interview for Mental Status (BIMS) score of 1, which indicates R3's cognition is severely impaired. Social Services Progress Note for R3 dated 10/24/19, documented that V10 was the POA. R3's New Admission Information Sheet, dated 10/24/19, listed V10 as the emergency contact with contact information R3's MAR's for November, December (2019), January, and February (2020) were reviewed. R3's Medication Administration Records shows R3's insulin was refused or not administered by nursing staff 22 times in November 2019, 36 times in December, 87 times in January, and 7 times in February until discharged on [DATE]. physician's orders [REDACTED]. R3's MARs and Blood Glucose/ Accucheck Sheets for November 2019 until February 2020 were reviewed and found R3's blood sugar testing was refused or not done by nursing staff a total of 174 times during those months. On 8/31/20 at 1:00 PM, V14 (Nurse Practitioner) states that she was not aware that R3 refused her insulin 130 times and glucose monitoring 174 times. V14 said she did not realize R3 refused so many times and the nursing staff did not notify her as ordered to do so. R3's nursing home medical records were reviewed and no documentation to indicate R3's next of kin or resident representative had ever been notified of R3's multiple refusals for blood sugar testing and/or insulin injection. On 8/31/20 at 1:00 PM, V14 (Nurse Practitioner) stated she had written orders for the nurses and V11 (Social Services Director) to contact the family regarding R3's refusal of insulin. V14 states she never heard back from the facility about reaching out to V10. On 8/26/20 at 4:00 PM, V5 (Registered Nurse) stated she recalled R3 refusing her insulin often. V5 said she did not notify the family because she worked night shift and thought V11(Social Service) and the day shift nurses had contacted the family about R3 refusing insulin. V5 was unable to determine if nursing staff had contacted V3's family. On 8/27/20 at 11:00 AM, V9 (Registered Nurse) stated she was aware of R3's refusing insulin injections but did not notify the family of the refusal. On 8/27/20 at 12:30 PM, V11(Social Service Director) stated that she thought nursing staff had contacted V10 about R3 refusing insulin and did not notify V10 of R3's multiple insulin refusals. On 8/27/20, both V6 (Family) and V10 (Family) stated that V10 was the POA. V6 stated that no one from the facility had contacted her or V10 about R3's multiple insulin refusals. On 8/27/20 at 12:00 PM, V10 states he was not made aware that R3 was refusing insulin until R3 was transferred to the emergency roiagnom on [DATE]. On 8/26/20, V2 (Director of Nursing), V7 (Licensed Practical Nurse), and V4 (Licensed Practical Nurse) all stated that if a resident refuses medication, the nursing staff is to notify the resident's doctor, family, and the Director of Nursing. A facility policy titled Notification for Change in Resident Condition or Status (revised 11/18/2017) states The facility and/or facility staff shall promptly notify appropriate individuals (i. e., Administrator, DON (Director of Nursing), Physician, Guardian, HCPOA (Health Care Power of Attorney), ect) of changes in the resident's medical/mental condition and/or status and Refusals of treatment or medications (i.e., three or more consecutive times). A facility policy titled Medication Administration (revised 11/18/2017) states Licensed nursing personnel .will notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason.
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a plan of care, follow physicians' orders and provide care in accordance with professional standards of practice for the treatment of [REDACTED]. This failure resulted in R3 being found unresponsive, having critically high blood sugar levels above 1200mg/dL and requiring R3 to be sent to the local emergency room for treatment on [DATE]. R3's condition deteriorated at the emergency room causing R3 to be transferred to the Intensive Care unit at a larger hospital. R3 expired on [DATE] with cause of death listed as Acute [MEDICAL CONDITION], Multiorgan Failure [MEDICAL CONDITION], and [MEDICAL CONDITIONS]. These failures resulted in an immediate jeopardy, which was identified to have begun on [DATE], when the facility failed to administer insulin as prescribed to R3. This has the potential to affect 13 residents, with diabetes, living in the facility. V15 (Licensed Practical Nurse), V25 (Regional Director of Clinical Operations) and V26 (Regional Director of Operations) were notified of the Immediate Jeopardy on [DATE] at 3:45 PM. The surveyors confirmed by observations, record review, and interview, that

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. BUILDING _____ B. WING _____	09/16/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) the Immediate Jeopardy was removed on [DATE], but non-compliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of in service training. Findings include: R3's New Admission Information Sheet in the medical record show R3 was admitted to this facility on [DATE] and was discharged to the local hospital for emergency treatment of [REDACTED]. R3's Cumulative [DIAGNOSES REDACTED]. [REDACTED]. On [DATE] at 12:00 PM, V15 was interviewed regarding R3's stay at this nursing home. V15 stated if a resident has the [DIAGNOSES REDACTED]. V15 states she forgot to add a plan of care for R3's Diabetes. R3's Medication Administration Records (MAR) and Physicians Order Sheets for [DATE] to February 2020 were reviewed. Physician order [REDACTED]. sugars at the times indicated. V15 said any initials circled on the MAR indicates the insulin was refused, and if no initials are present it indicates the insulin was not offered and not given. From [DATE] until R3's transfer to the hospital on February 2, 2020, R3 refused or was not given insulin as ordered 152 times (22 times in November, 36 times in December, 87 times in January, and 7 times in February). R3's physician's orders [REDACTED]. R3's MARs and forms titled Blood Glucose/ Accucheck Sheet, in the medical record for [DATE] until February 2020, were reviewed and found R3's blood sugar testing was refused or not done by nursing staff a total of 174 times from [DATE] until February 2, 2020, when R3 was transfer to the hospital emergency room for acute treatment of [REDACTED]. On [DATE], R3 was seen by V14 (Nurse Practitioner) for noncompliance of insulin and blood sugar testing and wrote a new order for the nursing staff to notify V14 if R3 continued to refuse her ordered insulin injections or blood sugar testing. On [DATE] at 1:00 PM, V14 states that she was not aware that R3 refused her insulin 130 times and glucose monitoring 171 times after V14 wrote the order for the nursing staff to notify her of R3's refusals on [DATE]. V14 said she did not realize R3 refused so many times and the nursing staff definitely did not notify her as ordered to do so. R3's physician's orders [REDACTED]. The dosage scale states to Notify the MD if blood glucose is over 350 mg/dL. R3's MAR and form titled Blood Glucose/ Accucheck Sheet in the medical record for [DATE] until February 2020 were reviewed. R3's records indicate that R3's blood glucose level was over 350 mg/dL a total of 49 times from [DATE] until R3 was transferred to the hospital on [DATE] (16 times in November, 18 times in December, 14 times in January, and 1 time in February.) On [DATE] at 1:00 PM, V14 states that V14 and V20 were not notified every time R3's blood glucose level was over 350. V14 further states that the facility utilizes an afterhours physician service company after 4:30 PM when physician notification is needed. On [DATE] at 2:10 PM, V21 (Medical Director of afterhours physician service company) states that the facility utilized their services on 5 occasions (2 times on [DATE], [DATE], [DATE], and [DATE]) to notify a physician of a blood glucose level above 350 mg/dL. V14 also said if there isn't documentation in R3's medical record stating she (V14) and V20 were notified of a blood glucose level over 350 mg/dL, then V14 and V20 were not notified. R3's nursing home medical records were reviewed from [DATE] through February 2020, and no documentation of V14 or V20 being notified of R3's blood sugars being above 350mg/dL were found. V1 (Administrator) reviewed R3's medical records and could not find any documentation of V14 or V20 being notified any of the 49 times R3's blood sugar test results were recorded as being over 350mg/dL. On [DATE] at 7:45 PM, Nurses Notes state that R3 was found unresponsive in her room, R3's blood sugar was checked at that time, and the glucometer results were displayed as high. As verified by V15, The User Instruction Manual for the Glucometer that is used by the facility on R3, states that when the blood sugar reading is displayed as high, it indicates that the blood sugar level is greater than 600 mg/dL and R3 was transported to the local emergency room . The local ER (emergency room) records states that R3's blood glucose level was 1250 mg/dL when she arrived at 9:30 PM. Due to R3's severe level of medical distress, R3 was transferred and admitted to Intensive Care Unit at a larger hospital more equipped to provide the critical care R3 needed 2 ,[DATE] hours later. Hospital Admission History and Physical notes state that Diabetic Ketoacidosis was suspected at the time admission. According to the Mayo Clinic Laboratory website (https://www.mayocliniclabs.com/it-mmfiles/DLMP_Critical_Values_-_Critical_Results_List.pdf), serum blood glucose level of 400 mg/dL or higher is considered a critical value. The Mayo Clinic Laboratory defines a critical value as A value/result that represents a pathophysiological state at such variance with normal (expected values) as to be life-threatening unless something is done promptly and for which some corrective action could be taken. R3's forms titled Blood Glucose/ Accucheck Sheet in the medical record and MAR's for [DATE] through February 2020 show R3's blood glucose level was 400mg/dL or higher 16 times (7 times in November, 3 times in December, 5 times in January, and 1 time in February). On [DATE] at 1:00PM, V14 (Nurse Practitioner) said the facility could have done more to prevent R3's condition from becoming so critical and The facility did not do everything they could have done. On [DATE] at 4:30 PM, V22 (Registered Nurse/ Director of Nursing at a local hospital where R3 was admitted) stated that she was the nurse who admitted R3 to the Intensive Care Unit. V22 states that R3 was very sick when she arrived at the hospital and felt that R3 did not receive very good care at the Nursing Home. On [DATE] at 10:00AM, V16 (Hospitalist for the Intensive Care Unit) stated she provided care for R3 in the Intensive Care Unit. V16 states that R3 was in poor condition and was receiving poor care while at the Nursing Home. R3 expired on [DATE]. R3's death certificate, completed by V16, states cause of death is Acute [MEDICAL CONDITION], Multiorgan Failure [MEDICAL CONDITION], and [MEDICAL CONDITIONS]. An Immediate Jeopardy was identified to have begun on [DATE] when the facility failed to administer insulin to R3 as prescribed. V15 (Licensed Practical Nurse), V25 (Regional Director of Clinical Operations) and V26 (Regional Director of Operations) were notified of the Immediate Jeopardy on [DATE] at 3:45 PM. On [DATE] the surveyor confirmed through interview and record review that the facility took the following actions to remove the Immediacy: The facility completed audits of Care Plans, Medication Administration Records, blood glucose monitoring, 24 hour nursing report and MD notication on [DATE]. The facility assigned staff member V15, LPN (Licensed Practical Nurse), began In-servicing Nursing staff on Diabetes, Care Plans, Conformance with physician orders, MD and POA notification of change in condition and refusal of treatment on [DATE]. Systematic & ongoing review of notification of change in condition are being completed daily by QA Committee. All began on [DATE] and was completed on [DATE], but QA review will be ongoing. The facility assigned staff member V15, LPN, to review the 24 hour nursing report daily for changes in condition and QA reviews are done daily, weekly, and monthly. The facility assigned staff member V15, LPN, to complete Care Plan audits, glucose monitoring and medication administration record review. These reviews are done daily. The facility assigned staff member V15, LPN, to in-service staff regarding the facility Conformance with Physician order [REDACTED]. Date completed [DATE]. The facility assigned staff member V15, LPN, to in-service staff regarding the facility policies for Physician Notification and glucose monitoring on [DATE]. Daily QA review of 24 hour report and review of telephone orders , daily chart reviews to ensure MD notification is completed as policy requires. Date completed [DATE]. The facility assigned staff member V15, LPN, to in-service staff on [DATE] regarding AIM for Wellness and communication for change in condition. Date completed: [DATE]. The facility assigned staff member V15, LPN, to in-service staff on [DATE] of refusal of treatment and MD notification. Date completed: [DATE]. The facility will continue to In-service staff regarding Diabetes, blood glucose monitoring, conformance with physician orders, Notification of change in condition, Aim for Wellness and Care Plans.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to follow physicians order and did not administer insulin injections to a patient with Diabetes Mellitus for 1 of 2 residents (R3) reviewed for medication administration in a sample of 8. Findings include: R3's Cumulative [DIAGNOSES REDACTED]. Inject subcutaneously before meals and at bedtime. If blood sugar is 70-140 mg/dL give 0 units, 141-180 mg/dL give 2 units, 181-220 mg/dL give 4 units, 221-260 mg/dL give 6 units, 261-300 mg/dL give 8 units, 301-350 mg/dL give 10 units, and if blood sugar over 350 mg/dL notify the MD. The facility policy titled Medication Administration (revision date 11/18/17) was reviewed. Procedure step 16 states, After a drug is given, record the date, time, name of drug, dose and route on the resident's Medication Administration Record. Step 19 states, Document any medications not administered for any reason by circling initials and documenting on the back of the MAR indicated [REDACTED]. On 8/31/20 at 12:00 PM, V15 (MDS Coordinator/ Care Plan Coordinator/ Licensed Practical Nurse) states that if the MAR indicated [REDACTED]. R3's Medication Administration Records (MAR) were reviewed for November 2019, December 2019, January 2020, and February 2020. There are no initials on the MAR's to indicate if insulin was administered a total of 38 times during those months. (3 times in November 2109, 16 times in December 2019, and 19 times in January 2020). MAR's and a document titled Blood Glucose/ Accucheck Sheet were reviewed for recording of R3's blood sugars for November 2019, December 2019, and January 2020. R3's blood sugar was not documented or checked 31 times out of the 38 times the insulin administration was not completed to determine what dosage of insulin R3 should have received. R3's blood sugar was documented as 333mg/dL on 11/7/19 indicating 10 units of [MEDICATION NAME]should have been administered, on 12/5/19 R3's blood sugar was 266mg/dL indicating 8 units of insulin should have been administered, and on 1/2/20 R3's blood sugar was 251mg/dL indicating 6 units of insulin should have been administered. The insulin was not documented as given on these

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145517	A. BUILDING _____ B. WING _____	**09/16/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) days. On 12/13/19, 1/17/20, 1/20/20 and 1/27/20, R3's blood sugar was greater than 350 mg/dL indicating that the physician should be notified for insulin dosage order. Nurse's Notes, Physicians Progress Notes, and Skilled Progress Notes in the medical record were reviewed from November 2019 to February 2020 and no documentation was found regarding physician notification or as to why the prescribed insulin was not administered as ordered.