

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6004881	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/16/2020
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NAME OF PROVIDER OR SUPPLIER WHITE OAK REHABILITATION & HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 1700 WHITE STREET MOUNT VERNON, IL 62864
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S 000	Initial Comments Complaint Investigation #2051817/IL120845	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1010 h) 300.1210 b) 300.1210 d)2) 300.1220 b)3) 300.3240 a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care 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 resident care plan. 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999	Attachment A Statement of Licensure Violations	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

09/29/20

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S9999	<p>Continued From page 1</p> <p>following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>2) All treatments and procedures shall be administered as ordered by the physician.</p> <p>Section 300.1220 Supervision of Nursing Services</p> <p>b) The DON shall supervise and oversee the nursing services of the facility, including:</p> <p>3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.</p> <p>Section 300.3240 Abuse and Neglect</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These regulations are not met as evidenced by:</p> <p>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 Diabetes Mellitus, for 1 of 3 residents (R3) reviewed for Diabetes Mellitus care in a sample of 9. This failure</p>	S9999		

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WHITE OAK REHABILITATION & HCC
1700 WHITE STREET
MOUNT VERNON, IL 62864

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S9999	<p>Continued From page 2</p> <p>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 2/2/2020. 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 2/12/20 with cause of death listed as Acute Respiratory Failure, Multiorgan Failure Severe Sepsis, and Clostridium Difficile Colitis.</p> <p>Findings include:</p> <p>R3's New Admission Information Sheet in the medical record show R3 was admitted to this facility on 10/24/2019 and was discharged to the local hospital for emergency treatment of critically high blood sugar on 2/2/2020, per the Nurses Notes in the medical record. R3's Cumulative Diagnosis document (undated) shows R3 has the diagnosis of Diabetes Mellitus.</p> <p>R3's Care Plan, developed on 11/12/2019 by V15 (MDS/ Care Plan Coordinator/ Licensed Practical Nurse), did not include R3's diagnosis of Diabetes Mellitus and thus fails to include a plan of care to manage R3's diagnosis of Diabetes Mellitus, including multiple refusals to receive insulin injections. On 8/31/20 at 12:00 PM, V15 was interviewed regarding R3's stay at this nursing home. V15 stated if a resident has the diagnosis of Diabetes it should be on the Care Plan. V15 states she forgot to add a plan of care for R3's Diabetes.</p> <p>R3's Medication Administration Records (MAR) and Physicians Order Sheets for November 2019 to February 2020 were reviewed. Physician Order Sheet, dated 11/3/2019, showed R3's physician (V20) ordered R3 to receive insulin injections to</p>	S9999		

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S9999	<p>Continued From page 3</p> <p>be administered to R3 every day before meals and at bedtime, with a sliding scale dose to be given based on R3's blood 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 November 2019 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).</p> <p>R3's Physician's Order Sheet, dated 11/3/2019, showed to perform fingerstick blood sugar testing on R3 before meals and at bedtime. R3's MARs and forms titled "Blood Glucose/ Accucheck Sheet", in the medical record 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 from November 2019 until February 2, 2020, when R3 was transfer to the hospital emergency room for acute treatment of critically high blood sugar levels. On 12/3/2019, 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 8/31/20 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 12/3/2020. 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.</p> <p>R3's Physician's Order Sheets document an order dated 11/3/19 for insulin injections with a</p>	S9999		

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S9999	<p>Continued From page 4</p> <p>sliding scale dosage based on R3's glucose level. 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 November 2019 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 November 2019 until R3 was transferred to the hospital on 2/2/2020 (16 times in November, 18 times in December, 14 times in January, and 1 time in February.) On 8/31/20 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 9/1/20 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 11/30/20, 12/1/20, 12/3/20, and 2/2/20) 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 November 2019 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.</p> <p>On 2/2/20 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</p>	S9999		

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S9999	<p>Continued From page 5</p> <p>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 1/2 hours later. Hospital Admission History and Physical notes state that Diabetic Ketoacidosis was suspected at the time admission.</p> <p>According to the Mayo Clinic Laboratory website (https://www.mayocliniclabs.com/it-mmfiles/DLM_P_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 November 2019 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).</p> <p>On 8-31-2020 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 9/2/20 at 4:30 PM,</p>	S9999		

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S9999	Continued From page 6 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 9/1/20 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 2/12/20. R3's death certificate, completed by V16, states cause of death is Acute Respiratory Failure, Multiorgan Failure Severe Sepsis, and Clostridium Difficile Colitis. (A)	S9999		