	-	ID HUMAN SERVICES			FORM APPROVED
STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN	G	COMPLETED	
		146113	B. WING		C 09/01/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CUMBERI	AND REHAB & HEALTH			300 NORTH MARIETTA STREET	
				GREENUP, IL 62428	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 000	INITIAL COMMENTS	;	F 00	00	
	Complaint #1664826	5/IL87971			
	A partial extended su	-			
F 157	483.10(b)(11) NOTIF (INJURY/DECLINE/R		F 1	57	9/2/16
SS=J		(OOM, ETO)			
	-	iately inform the resident;			
		ent's physician; and if dent's legal representative			
	-	y member when there is an			
	accident involving the	e resident which results in			
		tential for requiring physician			
		cant change in the resident's sychosocial status (i.e., a			
		n, mental, or psychosocial			
		reatening conditions or			
	clinical complications significantly (i.e., a ne	); a need to alter treatment			
	existing form of treatr				
	-	commence a new form of			
		ion to transfer or discharge facility as specified in			
	§483.12(a).	racinty as specified in			
		promptly notify the resident sident's legal representative			
		nember when there is a			
		ommate assignment as			
	specified in §483.15(	(e)(2); or a change in Federal or State law or			
		ed in paragraph (b)(1) of			
	this section.	- <u>-</u> , . ,			
	The facility must reco	rd and periodically update			
		ne number of the resident's			
	legal representative c	or interested family member.			
L					
		SUPPLIER REPRESENTATIVE'S SIGNATU		TITLE	(X6) DATE

'S SIGI

09/15/2016

PRINTED: 10/19/2016

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		146113	B. WING			C 09/01/2016		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
CUMBERI	AND REHAB & HEALTH	ICC			300 NORTH MARIETTA STREET GREENUP, IL 62428			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 157	by: Based on record revi interview, the facility of notification of chest p (R1). This failure resu completed acute myo attack), resulting in he These failures resulte Jeopardy. While the immediacy facility remains out of two. The facility is in the effectiveness of s Management, Physic Change in Condition. use of Care Paths (in Shortness of Breath), Report Sheets, Nurse proper nursing asses notification for are con timely manner. Findings include: The Physician Order August 2016 docume Cardiac Disorders, He Right Hip Fracture. The documents orders for	is not met as evidenced iew, observation and delayed physician ain for one of one resident uited in R1 sustaining a cardial infarction (heart eart damage. ed in an Immediate was removed on 9/1/16, the compliance at severity level the process of evaluating taff re-education on Pain ian Notification of Resident In addition to monitoring the cluding Chest Pain and Pain Flow Sheets, Shift es Notes, and ensuring sments with physician mpleted accurately and in a Sheet (POS) for R1 dated nts the following diagnoses: eart Failure and Status Post he same POS for R1	F	157				
	of acetaminophen, or hours as needed for p milligrams twice a day	ne to two tablets every six pain and Oxycodone 10						

Facility ID: IL6002307

If continuation sheet Page 2 of 24

						FORM	D: 10/19/2016 APPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI	E CONSTRUCTION	(X3) DATE	0. 0938-0391	
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
						(	C	
		146113	B. WING			09/	01/2016	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CUMBERI	AND REHAB & HEALTH	I CC			300 NORTH MARIETTA STREET			
					GREENUP, IL 62428			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
TAG F 157	Continued From page R1, dated 8/19/16 at a is alert and oriented, f The facility policy title Resident Condition or directs facility staff to facility and/or facility s appropriate individual Director of Nursing, P Care Power of Attorner resident's medical/me statusany symptor discomfort that is: suc change unrelieved by prescribedA signifi resident's physical/en need to alter a reside significantlyabnorm nurse supervisor/chai (Director of Nursing), otherwise instructed to resident's next of kin. any of the afore ment Facility Nurses Notes following over a 21.5 08/19/16 at 9:00PM b Practical Nurse: " Pa HRRR (heart Rate an states ' I just want to Reminded (R1) that ( hospital because she On 08/20/16 at 3:00A awake most of shift. " On 08/20/16 at 11:00	<ul> <li>2</li> <li>5:30 pm documents that R1 to person, place and time.</li> <li>d "Notification for Change in r Status" dated 7/1/12 perform the following: "The staff shall promptly notify is (i.e., Administrator, Physician, Guardian, Health ey, etc) of changes in the ental condition and/or m, sign or apparent dden in onset, a marked measures already icant change in the notional/mental condition. A nt's medical treatment hal complaints of pain The rge nurse will notify the DON Physician and unless by the resident, thewhen the resident has ioned situations"</li> <li>for R1 documents the hour time span:</li> <li>by E12 LPN (Licensed tient complaint of chest pain of Rhythm Regular). Then go back to the hospital. 'R1) could not just go back to wanted to. "</li> <li>M E13 RN (Registered hplains of shortness of</li> </ul>		157	DEFICIENCY)	ATE	DATE	
	On 08/20/16 at 11:00 Nurse): " Patient con breath, patient very u	AM E13 RN (Registered pplains of shortness of						

Facility ID: IL6002307

If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       146113       B. WING       09/01/2016         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       09/01/2016         CUMBERLAND REHAB & HEALTH CC       STREET ADDRESS, CITY, STATE, ZIP CODE       300 NORTH MARIETTA STREET GREENUP, IL 62428         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)			ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/19/2016 MAPPROVED D. 0938-0391	
148113         P. WNG         09/01/2016           INAME OF PROVIDER OR SUPPLIER         SIREET ADDRESS, CITY, STATE, 2/P CODE         SO NORTH MARIETTA STREET         OB NORTH MARIETTA STREET         OCCURRENT CODE         ON NORTH MARIETTA STREET         OCCURRENT CODE         ON NORTH MARIETTA STREET         OCCURRENT CODE         ON NORTH MARIETTA STREET         OCCURRENT CODE         OCCURRENT CODE </td <td>STATEMENT (</td> <td colspan="2"></td> <td>. ,</td> <td></td> <td></td> <td colspan="3">COMPLETED</td>	STATEMENT (			. ,			COMPLETED		
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R1's care the evening of 8/19/16, stated R1 did complain of chest pain, but R1 was vague about it and wasn't showing any facial grimacing. E12 stated that E12 did not ask the resident to rate the chest pain or "at least I don't remember if I did." E12 stated that E12 did not give any pain medication because E12 did not have the code to get into the narcotic convenience box. E12 stated the pharmacy has the code and did not answer when E12 had called. E12 stated that R1 arrived from the hospital at approximately 5:30 pm. "It was dinner time." E12 stated that E12 did not remember that after hours pharmacy needed to be called for the narcotic box code. E12 stated "I									
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medication because E12 did not have the code to get into the narcotic convenience box. E12 stated the pharmacy has the code and did not answer when E12 had called. E12 stated that R1 arrived from the hospital at approximately 5:30 pm. "It was dinner time." E12 stated that E12 did not remember that after hours pharmacy needed to be called for the narcotic box code. E12 stated "I		the chest pain or "at I	east I don't remember if I						
The pharmacy has the code and did not answer when E12 had called. E12 stated that R1 arrived from the hospital at approximately 5:30 pm. "It was dinner time." E12 stated that E12 did not remember that after hours pharmacy needed to be called for the narcotic box code. E12 stated "I		medication because I	E12 did not have the code to						
from the hospital at approximately 5:30 pm. "It was dinner time." E12 stated that E12 did not remember that after hours pharmacy needed to be called for the narcotic box code. E12 stated "I		the pharmacy has the	e code and did not answer						
remember that after hours pharmacy needed to be called for the narcotic box code. E12 stated "I		from the hospital at a	pproximately 5:30 pm. "It						
		remember that after h	nours pharmacy needed to						
acknowledged that R1's physician had not been		had all these other re	sidents to deal with." E12						

Facility ID: IL6002307

If continuation sheet Page 4 of 24

	-	ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED		
		146113	B. WING			C 09/01/2016		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
					300 NORTH MARIETTA STREET			
CUMBERI	AND REHAB & HEALTH	ICC			GREENUP, IL 62428			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 157	responsible for R1's of 8/19/16 (10:00 pm to received report from R had complained of ch complainer. E3 stated chest pain to E3, but get into the narcotic b stated she did not kno pharmacy for the cod R1's complaints of ch charted and did not kno pharmacy for the cod R1's complaints of ch charted and did not kno pharmacy for the cod R1's complaints of ch charted and did not kno chest pain. E3 stated to the day nurse, E15 R1's chest pain. E3 a physician had not bee or the unavailable pai On 8/25/16 at 1:35 pm responsible for R1's of acknowledged that re through the shifts had stated that R1 had co shortness of breath. E upset and anxious." E there were no pain m R1. E13 stated I didn' E13 stated that report shortness of breath w the evening Registere acknowledged that R	am E3 LPN, the employee care on the night shift of 6:00 am), stated that E3 E12 and E12 stated that R1 rest pain but R1 was a d that R1 also complained of E3 did not have a code to box for pain medication. E3 ow to call the after-hours e. E3 acknowledged that est pain had not been now why E3 didn't chart the she had passed on in report FRegistered Nurse about cknowledged that R1's en notified of the chest pain in medication. The E13 RN, the employee care the day of 8/20/16, sport about R1's chest pain d been reported to E13. E13 implained of chest pain and E13 stated (R1) was very E13 stated that E13 was told edications in the building for 't look in the narcotic box." t of R1's chest pain and vas passed on in report to ed Nurse, E14. E13 1's chest pain and the medication had not been	F	157				
	responsible for R1's of	n E14 RN, the employee care the evening of 8/20/16, s received from E13 about						

Facility ID: IL6002307

If continuation sheet Page 5 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/19/2016 // APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE SURVEY COMPLETED	
		146113	B. WING				C 01/2016
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBER	LAND REHAB & HEALTH	CC			800 NORTH MARIETTA STREET GREENUP, IL 62428		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 157	R1's chest pain and a E14 stated that R1 wa narcotic count was fin assessment R1 looke about pain and R1 sta R1's chest. R1 stated that the physician was thought it was referren E14 stated R1 was gi calling pharmacy for c later E14 checked on better describe the ch (Z2) was notified and emergency room A facility report titled ' Assessment dated 8/2 that R1 was transferren R1 's Hospital Emerg 8/20/16 at 7:11 pm dc History of Present Illin (R1)reports onset of s arrivalthe patient m pain medication but w was having chest pain Course Notes docume consistent with an Act The Notes continue "( through numerous ev symptoms are consist completed myocardia Hospital Records date R1 developed onset of sent to a specialized I Specialized Hospital I	Inviousness and agitation. as assessed after report and hished. E14 stated on d exhausted. R1 was asked ated "I hurt" and pointed to again "I hurt." E14 stated is not called because E14 d pain from R1's right hip. ven pain medication after code access. E14 stated R1 and R1 was able to hest pain and the physician R1 was sent to the 'Nursing Transfer/Discharge 20/16 at 6:35 pm documents ed to the local hospital. gency Room records dated bocuments the following: ess"The patient symptoms 30 hours prior to eports that she received vas not evaluated while she h." Emergency Room ent that R1's tests are ute Myocardial Infarction. (R1) remained pain-free aluations and (R1's) tent unfortunately with a I infarction." The same ed 8/21/16 document that of chest pain again and was hospital per ambulance. Reports dated 8/21/16	F	157			

Facility ID: IL6002307

If continuation sheet Page 6 of 24

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/19/2016 APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		146113	B. WING		_		C 01/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
CUMBERL	AND REHAB & HEALTH	сс		300 NORTH MARIETTA ST GREENUP, IL 62428	REET			
					S PLAN OF CORRECTION		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 157	Continued From page	6	F 157	,				
	R1 having a 100% blo Coronary Artery with s	ockage of the Right						
	facility staff would be having chest pain or o "Absolutely I should h immediately of (R1's) On 8/25/16 at 8:00 an in the hospital bed. R person, place and tim surroundings and was sequence of events th stated that R1 had sta after arriving at the low 5:30 pm. R1 stated th	ed that the expectation of to notify Z1 if a resident is liscomfort. Z1 stated ave been notified chest pain." In R1 was sitting up supine 1 was alert and oriented to e. R1 was aware of R1's is able to discuss the nat led to hospitalization. R1 arted having chest pain just ing term care facility around e nurses were told about it						
	"my call light wasn't e for help. I was hot and to the hospital. The nu hatefully that just beca hospital did not mean E12 told R1 that E12 care of. R1 stated that came back later and f	vere ignoring R1. R1 stated ven working and I had to yell d sweaty and wanted to go urse E12 told me very ause I wanted to go to the I could go. R1 stated that had other residents to take t E12 shut the door and ixed the call light. R1 stated e any pain medication until						
	the next day in the aft did not sleep all night R1 would get out of th tearful at this time and my life. It was a night something was going would listen. They ma and didn't know what	ernoon. R1 stated that R1 and was up up praying that he facility alive. R1 was d stated "I was scared for						

Facility ID: IL6002307

If continuation sheet Page 7 of 24

		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		146113	B. WING			C 09/01/2016		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CUMBER	AND REHAB & HEALTH	сс			300 NORTH MARIETTA STREET GREENUP, IL 62428			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 157	On 8/25/16 at 9:40 ar Physician stated that emergency room R1's a completed acute my a 24 hour period. Z3 s transport from the fac in intervention and mo been a result. Z3 state muscle damage from stated "I believe (R1) that facility." On 8/31/16 an Immedi identified. The immedi began on 8/19/16 who physician notification resulting in R1 sustain notified of the Immedi 1:25pm. The surveyor was abl review and interview f following actions to re 1. Nurses will or have Corporate Administrator Prevention Policy (inc prevention), obtaining and medications after box, notification to ph are not readily access Policy of a resident's Cards and Care Paths shortness of breath; F for resident emergend	n Z3, Emergency Room when R1 arrived in the a tests were consistent with vocardial infarction (MI) over stated that the delay in ility certainly caused a delay orbidity (death) could have ed R1 certainly has heart the completed MI. Z3 had a horrific experience at liate Jeopardy was diate jeopardy situation en the facility delayed of chest pain for R1 hing heart damage. E1 was ate Jeopardy on 8/31/16 at e to confirm through record that the facility took the move the immediacy: e been in-serviced by a tor, the Director of Nursing, of the facility on: Pain duding assessment and controlled pain medication hours from the contingency ysician when medications sible; Physician Notification change in condition; Care s including chest pain and Physician order not required cy transport; and neglect with policies. Corporate	F	157				

Facility ID: IL6002307

If continuation sheet Page 8 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/19/2016 MAPPROVED D. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		146113	B. WING				C / <b>01/2016</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBER	LAND REHAB & HEALTH				300 NORTH MARIETTA STREET		
					GREENUP, IL 62428		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224 SS=J	MISTREATMENT/NE	GLECT/MISAPPROPRIATN	F	224	4		9/2/16
	policies and procedur	es that prohibit t, and abuse of residents					
	by: Based on record revi neglected to follow fa Management/adminis Resident's Change in neglected to follow th notification and notify (R1) change of condit (R1) reviewed for pain This failure resulted in without pain intervent	stration and Notification of a Condition. The facility also eir policy on physician the physician of a resident's tion for one of one resident n in the sample of three. n R1 going over 21 hours ion and delayed physician ain resulting in R1 suffering n with heart damage.					
	While the immediacy facility remains out of two. The facility is in the effectiveness of s Management, Physic Change in Condition. use of Care Paths (in Shortness of Breath), Report Sheets, Nurse	was removed on 9/1/16, the compliance at severity level the process of evaluating taff re-education on Pain ian Notification of Resident In addition to monitoring the cluding Chest Pain and Pain Flow Sheets, Shift es Notes, and ensuring sments with physician					

If continuation sheet Page 9 of 24

		ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED 8 NO. 0938-0391	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVE COMPLETED			
		146113	B. WING			C 09/01/2016		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
CUMBERI	AND REHAB & HEALTH	ICC			300 NORTH MARIETTA STREET GREENUP, IL 62428			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 224	timely manner. Findings include: The facility policy title Treatment" dated Jan staff to perform the for reduce the incidence an effort to minimize the Assessment of pain or changes in the reside of pain or evidence of of the presence of pain nursing notes or on the Sheet. This will include rating, treatment inter response." The facility policy title Resident Condition on directs facility staff to facility and/or facility sa appropriate individual Director of Nursing, P Care Power of Attorner resident's medical/me statusany symptor discomfort that is: suc change unrelieved by prescribedA signiff resident's physical/en need to alter a reside significantlyabnorm nurse supervisor/chan (Director of Nursing), otherwise instructed to	d "Pain Prevention and huary 2010 directs facility flowing: "To assess for, of and the severity of pain in further health problems will be completed with ent's condition, self reporting f behavioral cues indicative in and documented in the ne Pain Management Flow de, but is not limited to, date, vention and resident d "Notification for Change in r Status" dated 7/1/12 perform the following: "The staff shall promptly notify ls (i.e., Administrator, Physician, Guardian, Health ey, etc) of changes in the ental condition and/or m, sign or apparent dden in onset, a marked r measures already icant change in the notional/mental condition. A nt's medical treatment nal complaints of pain The rge nurse will notify the DON Physician and unless by the resident, the	F	224				
		when the resident has						

Facility ID: IL6002307

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
AND FLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _		C		
		146113	B. WING				01/2016	
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CUMBERL	AND REHAB & HEALTH	сс			300 NORTH MARIETTA STREET GREENUP, IL 62428			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 224	Continued From page	9 10	F	224	ı			
	-	r orders dated 8/19/16 direct ne physician of unrelieved						
	The Physician Order August 2016 docume Cardiac Disorders, He Right Hip Fracture. The documents orders for Hydrocodone 7.5 million of acetaminophen, or hours as needed for primilligrams twice a day The facility Admission R1, dated 8/19/16 at 4 is alert and oriented, for R1's nurses notes doo On 08/19/16 R1 comp LPN. No pain intervet documented. On 08/20/16 at 3:00A R1 had been awake m no documentation of a On 08/20/16 at 11:00 complained of being se upset. R1 's clinical for documentation of any On 08/20/16 at 3:30P R1 complained of pain chest stating " it just documents R1 was gi	pain medication of grams and 325 milligrams te to two tablets every six pain and Oxycodone 10 y as needed for pain. Nursing Assessment for 5:30 pm documents that R1 to person, place and time. Cument the following: plained of chest pain to E12 ntions/medications were M E3 LPN documented that nost of the night. There was any pain assessment. E13 documented that R1 short of breath and was very record contains no intervention. M E14 RN documented that n in the upper abdomen and hurts. " At 3:55PM E14 ven Norco. At 6:20PM E14						
	documents R1 was gi documents that R1 was stated the pain was s	ven Norco. At 6:20PM E14 as sitting up in bed and till there. At 6:30PM E14 who gave orders to call 911						

Facility ID: IL6002307

If continuation sheet Page 11 of 24

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/19/2016 APPROVED D: 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		146113	B. WING		_		C 01/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-		
				300 NORTH MARIETTA ST	REET			
CUMBERL	AND REHAB & HEALTH	CC		GREENUP, IL 62428				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
TAG F 224	Continued From page A facility report titled " Assessment dated 8/2 that R1 was transferre On 8/24/16 at 1:55 pm Practical Nurse), the e R1's care the evening complain of chest pain and wasn't showing a stated that E12 did no the chest pain or "at le did." E12 stated that E medication because E get into the narcotic c the pharmacy has the when E12 had called. from the hospital at ap was dinner time." E12 remember that after h be called for the narcot had all these other res acknowledged that fac followed and that E12 policy on pain and phy On 8/24/16 at 11:15 a responsible for R1's c	11 Nursing Transfer/Discharge 20/16 at 6:35 pm documents ed to the local hospital. In E12 LPN (Licensed employee responsible for of 8/19/16, stated R1 did n, but R1 was vague about it ny facial grimacing. E12 at ask the resident to rate east I don't remember if I E12 did not give any pain E12 did not give any pain E12 did not have the code to onvenience box. E12 stated code and did not answer E12 stated that R1 arrived oproximately 5:30 pm. "It estated that E12 did not ours pharmacy needed to otic box code. E12 stated "I sidents to deal with." E12 cility policy had not been had knowledge of the ysician notification. m E3 LPN, the employee are on the night shift of	F 224			ITE	DATE	
	had knowledge of R1' from the previous nur	6:00 am), stated that E3 s complaints of chest pain se (E12) but E12 had also complainer. E3 stated that						
	R1 did complain to E3 the night but did not h box. E3 acknowledge policies on pain and p acknowledged that R <sup>2</sup> had not been treated	B about chest pain during ave access to the narcotic d awareness of the facility hysician notification. E3 I's complaints of chest pain with pain medication or I Record. E3 stated R1's						

Facility ID: IL6002307

If continuation sheet Page 12 of 24

		ID HUMAN SERVICES				FORM	D: 10/19/2016 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLI	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		146113	B. WING				C 01/2016
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBER	LAND REHAB & HEALTH	CC			300 NORTH MARIETTA STREET GREENUP, IL 62428		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 224	Continued From page	9 12	F	224			
	On 8/25/16 at 1:35 pr responsible for R1's of acknowledged that R pain and shortness of was very upset and a was told there were in building for R1. E13 st pain and shortness of report to the evening acknowledged that R notified of R1's chest On 8/25/16 at 2:55 pr responsible for R1's of stated that E14 had re complaints of chest p anxiousness. E14 stat report and narcotics w that on assessment F was asked about pair chest hurt. E14 stated medication after callir access. E14 stated th and after prompting, w pain better. (Z2) was the emergency room. R1's Emergency Roo 8/20/16 at 7:11 pm do History of Present Illin (R1)reports onset of s arrivalthe patient r pain medication but w was having chest pain	n E13 RN, the employee care the day of 8/20/16, 1 had complained of chest f breath. E13 stated (R1) nxious." E13 stated that E13 o pain medications in the stated I didn't look in the ated that report of R1's chest f breath was passed on in E14 RN. E13 1's physician had not been pain or pain medication. In E14 RN, the employee care the evening of 8/20/16, eccived in report R1's ain, agitation and ted R1 was assessed after vere counted. E14 stated R1 looked exhausted. R1 o and R1 stated that R1's ed R1 was given pain ng pharmacy for code tat R1 was checked on later was able to describe the notified and R1 was sent to m hospital records dated ocuments the following:					

Facility ID: IL6002307

If continuation sheet Page 13 of 24

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/19/2016 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		146113	B. WING				C 01/2016
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND REHAB & HEALTH	сс			300 NORTH MARIETTA STREET GREENUP, IL 62428		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	with an Acute Myocar Physician documents through numerous ev are consistent, unfort myocardial infarction. 8/21/16 document that chest pain again and hospital per ambuland Specialized Hospital I document that R1 und Catheterization and w blockage in the Right On 8/24/16 at 1:35 pr Physician stated that staff would be to notif chest pain or discomf should have been not chest pain." On 8/2/5/16 at 9:40 at Physician stated that emergency room, R1' a completed myocard hour period. Z3 stated from the facility certai intervention and more been a result. Z3 stated muscle damage from stated "I believe (R1) that facility." On 8/25/16 at 8:00 ar in the hospital bed. R person, place and tim surroundings and was sequence of events th	dial Infarction. Z3, Hospital "R1 remained pain-free aluations and her symptoms unately with a completed " Hospital Records dated at R1 developed onset of was sent to a specialized be: Reports dated 8/21/16 derwent a Cardiac vas found to have 100% Coronary Artery. In Z1, Primary Care the expectation of facility y Z1 if a resident is having ort. Z1 stated "Absolutely I ified immediately of (R1's) Im Z3, Emergency Room when R1 arrived in the s tests showed indication of ial infarction (MI) over a 24 d that the delay in transport nly caused a delay in bidity (death) could have ed R1 certainly has heart the completed MI. Z3 had a horrific experience at In R1 was sitting up supine 1 was alert and oriented to e. R1 was aware of R1's s able to discuss the	F	224			

Facility ID: IL6002307

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	-	ID HUMAN SERVICES				FORM	/ APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU		E CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:					LETED
							c
		146113	B. WING				01/2016
NAME OF PF	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
	AND REHAB & HEALTH	199		3	300 NORTH MARIETTA STREET		
CONBERL				(	GREENUP, IL 62428		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 224	Continued From page	e 14	F	224	L		
	having chest pain just	t after arriving at the facility.					
		were told about it and R1					
		oring R1. R1 stated "my call					
		king and I had to yell for weaty and wanted to go to					
	-	se E12 told me very hatefully					
	•	anted to go to the hospital					
	did not mean I could g	go. R1 stated that E12 told					
		r residents to take care of.					
		iut the door and came back					
		I light. R1 stated that R1 did medication until the next day					
	÷ .	stated that R1 did not sleep					
		ip praying that R1 would get					
	-	. R1 was tearful at this time					
		red for my life. It was a					
	-	ew something was going on					
	•	one would listen. They made zy and didn't know what l					
		e I had dementia and I					
	•	be out of there and alive."					
	, ,						
	On 8/31/16 an Immed	1 2					
		diate jeopardy situation					
	follow facility policy or	en the facility neglected to					
		tration and Notification of a					
	-	Condition resulting in R1					
	going over 21 hours v	vithout pain intervention and					
	delayed physician not	•					
		ng a myocardial infarction					
	with heart damage. E						
	mmediate Jeopardy	on 8/31/16 at 1:25pm.					
	The surveyor was abl	e to confirm through record					
	-	that the facility took the					
	following actions to re	move the immediacy:					
	1. Nurses will or have	e been in-serviced by a					

Facility ID: IL6002307

If continuation sheet Page 15 of 24

STATE MENT OF DEFICIENCIES AND PLAN OF CORFECTION       (N) INFOUNDERSUPPORTURATION NUMBER: INFORMATION NUMBER:       (O2 NULTIFIE CONSTRUCTION A BUILDING       (O2 NUL			ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
A BOULING         C           NAME OF PROVIDER OR SUPPLIER           CUMBERLAND REHAB & HEALTH CC           COMBERLAND REHAB & HEALTH CC           COMMENT AND REHAB & HEALTH CC           OWNOT: SUMMARY STATEMENT OF DEPICIENCIES           Continued From page 15           F 224           Continued From page 15           C Corporate Administrator, the Director of Nursing, and the Administrator of the facility on: Pain Prevention Policy (including assessment and prevention), obtaining controlled pain medications are not readity accessible: Physician Notification of physician when medications are not readity accessible: Physician order not required for readient emergency transport; and neglect with failure to comply with policies. Corporate Administrator condition; Care Cards and Care Paths including chest pain and shortness of lorealtr. Physician order not required for readient emergency transport; and neglect with failure to comply with policies. Corporate Administrator condition; Care Cards and Care Paths including chest pain and shortness of lorealtr. Physician order not soft; and neglect with failure to comply with policies. Corporate Administrator completed on 8/3/11/6.         F 309         9/2/16         9/2/16         9/2/16         9/2/16           Factoreal of the control of the catility must provide the necessary care and services to attain or maintain the lighest practicable physical, mentai, and psychocial well-being, in accordance with the comprehensive assessment and plan of care.         F 309         9/2/16	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL		(X3) DATE	SURVEY
146113         B_WNO         09/01/2018           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, 2P CODEL         STREET ADDRESS, CITY, STATE, 2P CODEL         00 NORTH MARIETTA STREET           (PAI) ID PREEDX         STREET ADDRESS, CITY, STATE, 2P CODEL         00 NORTH MARIETTA STREET         00 NORTH MARIETA STREET	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	ING .			
300 NORTH MARIETTA STREET CREENUP, IL 62/23           OWNER PRETIX TAG         SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST RE PRECEDED BY FULL REGULTORY OF LSC DEPITIPING INFORMATION)         ID PRETIX TAG         PROVIDENTS TAVE OF CONSECTION (EACH OPPICENT ANTON SHOULD BE CROSS-REFERENCE) TO TAVE APPROPRIATE         COMMENTING DEFICIENCY           F 224         Continued From page 15 Corporate Administrator, the Director of Nursing, and the Administrator of the facility on: Pain Prevention Policy (including assessment and prevention), obtaining controlled pain medications are not readily accessible. Physician Notification Policy of a resident's change in condition; Care Cards and Care Paths including chest pain and shortness of breath; Physician order not required for resident emergency transport, and neglect with failure to completed on 8/31/16.         F 309         9/2/16           F 384         A32 SP ROVICES FOR SS=0         HIGHEST WELL BEING         F 309         9/2/16           Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.         F 309         9/2/16           This REQUIREMENT is not met as evidenced by: Traiter the status of the status provide the comprehensive assessment and plan of care.         F 309         Secondance with the comprehensive assessment and plan of care.			146113	B. WING				
GREENUP, IL 82428           (PA) ID PREFIX TAG         SUMMARY STATEMENT OF DIFICIENCIES (EACH ECRORED Y UAL OF CORRECTION (EACH ECRORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PREFIX (EACH ECRORET Y UAL OF CORRECTION (EACH ECRORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH ECRORET Y UAL OF CORRECTION (EACH ECRORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH ECRORY ECRORY TAG         PREFIX (EACH ECRORY OR LSC IDENTIFYING INFORMATION)         D PREFIX TAG         PREFIX (EACH ECRORY (EACH ECRORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         PREFIX (EACH ECRORY (EACH ECRORY OR LSC IDENTIFY INFORMATION)         PREFIX TAG         PREFIX (EACH ECRORY (EACH ECRORY OR LSC IDENTIFY INFORMATION)         PREFIX TAG         PREFIX (EACH ECRORY OR LSC IDENTI	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TXG       (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC DENTFYING INFORMATION)       PREFIX TXG       (EACH DERTIFYIE ALCORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         F 224       Continued From page 15 Corporate Administrator, the Director of Nursing, and the Administrator of the facility on: Pain Prevention Policy (including assessment and prevention), obtaining controlled pain medications are not readily accessible; Physician Notification Policy of a resident's change in condition; Care Cards and Care Paths including chest pain and shortness of breath; Physician order not required for resident emergency transport; and neglect with failure to comply with policies. Corporate Administrator completed on 8/31/16.       F 309       9/2/16         F 309       Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.       F 309         This REQUIREMENT is not met as evidenced by; Based on record review, observation and interview, the facility failed to address complaints of chest pain for one (R1) of three residents reviewed for pain in the sample of three. This failure resulted in R1's chest pain going untreated for 21.5 hours resulting in a myocardial infrarction       F 309	CUMBERI	AND REHAB & HEALTH	CC					
Corporate Administrator, the Director of Nursing, and the Administrator of the facility on: Pain Prevention Policy (including assessment and prevention), obtaining controlled pain medication and medications after hours from the contingency box, notification to physician when medications are not readily accessible; Physician Notification Policy of a resident's change in condition; Care Cards and Care Paths including chest pain and shortness of breath; Physician order not required for resident energency transport; and neglect with failure to comply with policies. Corporate Administrator completed on 8/31/16. F 309 483.25 PROVIDE CARE/SERVICES FOR SS=J HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to address complaints of chest pain for one (R1) of three residents reviewed for pain in the sample of three. This failure resulting in a myocardial infarction	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
(heart attack) with heart damage. These failures resulted in an Immediate Jeopardy.	F 309	Corporate Administration and the Administrator Prevention Policy (inc prevention), obtaining and medications after box, notification to ph are not readily access Policy of a resident's Cards and Care Paths shortness of breath; F for resident emergend with failure to comply Administrator comple 483.25 PROVIDE CA HIGHEST WELL BEIN Each resident must re provide the necessary or maintain the higher mental, and psychoso accordance with the of and plan of care. This REQUIREMENT by: Based on record revi interview, the facility f of chest pain for one of reviewed for pain in the failure resulted in R1's for 21.5 hours resultin (heart attack) with heat These failures resulted	tor, the Director of Nursing, of the facility on: Pain cluding assessment and g controlled pain medication hours from the contingency ysician when medications sible; Physician Notification change in condition; Care s including chest pain and Physician order not required cy transport; and neglect with policies. Corporate ted on 8/31/16. RE/SERVICES FOR NG eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment is not met as evidenced ew, observation and failed to address complaints (R1) of three residents to chest pain going untreated ag in a myocardial infarction art damage.					9/2/16

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 10/19/2016 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	
		146113	B. WING				C 101/2016
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		<u></u>		:	300 NORTH MARIETTA STREET		
CUMBER	LAND REHAB & HEALTH	CC .			GREENUP, IL 62428		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	While the immediacy facility remains out of two. The facility is in the effectiveness of st Management, Physici Change in Condition. use of Care Paths (im Shortness of Breath), Report Sheets, Nurse proper nursing assess notification for are cor timely manner. Findings include: Discharge Orders dat the local hospital doce Right hemiarthroplast The facility Physician dated August 2016 do diagnoses: Cardiac D Status Post Right Hip for R1 documents ord Hydrocodone 7.5 mg acetaminophen, one thours as needed for p twice a day as needed The facility policy title Treatment" dated Jan staff to perform the fo reduce the incidence an effort to minimize f Assessment of pain v changes in the reside of pain or evidence of pain or evidence of pain	was removed on 9/1/16, the compliance at severity level the process of evaluating taff re-education on Pain an Notification of Resident In addition to monitoring the cluding Chest Pain and Pain Flow Sheets, Shift is Notes, and ensuring sments with physician mpleted accurately and in a ed 8/19/16 at 1:37 pm from ument that R1 is Status Post y. Order Sheet (POS) for R1 ocuments the following isorders, Heart Failure and Fracture. The same POS ers for pain medication of (milligrams) and 325 mg of to two tablets every six pain and Oxycodone 10 mg d for pain. d "Pain Prevention and uary 2010 directs facility llowing: "To assess for, of and the severity of pain in further health problems	F	309			

Facility ID: IL6002307

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 10/19/2016 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	
		146113	B. WING				C 01/2016
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND REHAB & HEALTH	сс			300 NORTH MARIETTA STREET GREENUP, IL 62428		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 309	Sheet. This will includ rating, treatment inter response." The facility policy title Resident Condition or directs facility staff to facility and/or facility staff appropriate individual Director of Nursing, P Care Power of Attorne resident's medical/me statusany symptor discomfort that is: suc change unrelieved by prescribedabnormathe resident has any of situations" The facility Admission R1, dated 8/19/16 door oriented, to person, p The Nursing Note dat E12 Licensed Practica complaints of Chest p Rhythm Regular). The back to the hospital. F not just go back to ho to." R1's Pain Asses time documented), do pain. R1's Pain Mana documentation during At 3:00 am on 8/20/16 E3 documents in the f awake most of shift."	e, but is not limited to, date, vention and resident d "Notification for Change in Status" dated 7/1/12 perform the following: "The staff shall promptly notify s (i.e., Administrator, hysician, Guardian, Health ey, etc) of changes in the ental condition and/or n, sign or apparent dden in onset, a marked measures already al complaints of painwhen of the afore mentioned	F	309			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		146113	B. WING_				C / <b>01/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				3	300 NORTH MARIETTA STREET		
CUMBER	LAND REHAB & HEALTH	CC		C	GREENUP, IL 62428		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Registered Nurse doc of shortness of breath Nursing Notes dated Registered Nurse doc (upper abdomen) and when describing pain pharmacy for code to locked (narcotic) box. pm in the Nursing Noi still theregave two (hydrocodone with ac documents in the Nur R1 is sitting up in bed three, stating "pain noi (pointing to R1's ches more direct questionin stated 'when the pain pain that goes to both and into my back.' Nu at 6:30 pm E14 conta for Z1, Primary care F received to call 911 a emergency room for e On 8/24/16 at 1:55 pm Practical Nurse), the R1's care the evening complain of chest pai and wasn't showing a stated that E12 did noi the chest pain or "at le did." E12 stated that F medication because F get into the narcotic c the pharmacy has the when E12 had called. from the hospital at ap	cuments "Patient complains n, patient very upset" 8/20/16 at 3:30 pm by E14, cuments "Complains of pain 1 chest. Resident vague 'It just hurts' will contact get (pain medication) out of " E14 documents at 3:55 tes "Resident stated pain 7.5 mg /325 mg tetaminophen)." E14 sing Notes at 6:20 pm that a laert and oriented times of as bad but it is still there st)." E14 documents"Upon ng resident (R1) finally comes it's like a squeezing a shoulders down both arms ursing Notes document that cted Z2, on call physician Physician. A new order was nd send (R1) to the evaluation and treatment.	F	309			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		146113	B. WING				01/2016
NAME OF P	ROVIDER OR SUPPLIER		ł	9	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CUMBERI	LAND REHAB & HEALTH	сс			300 NORTH MARIETTA STREET GREENUP, IL 62428		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	remember that after h be called for the narch had all these other re- acknowledged that R called about the chess On 8/24/16 at 11:15 a responsible for R1's of 8/19/16 (10:00 pm to received report from H had complained of ch complainer. E3 stated of chest pain to E3, b get into the narcotic b stated she did not kn pharmacy for the cod R1's complaints of ch charted and did not kn chest pain. E3 stated to the day nurse, E13 R1's chest pain. E3 a physician had not bee pain or the lack of pai On 8/25/16 at 1:35 pr responsible for R1's of acknowledged that re through the shifts had stated that R1 had co shortness of breath. E upset and anxious." E there were no pain m R1. E13 stated I didn' E13 stated that report shortness of breath w the evening nurse, E <sup>4</sup>	e 19 nours pharmacy needed to obtic box code. E12 stated "I sidents to deal with." E12 1's physician had not been t pain or lack of medication. Im E3 LPN, the employee care on the night shift of 6:00 am), stated that E3 E12 and E12 stated that R1 est pain but R1 was a 1 that R1 also complained ut E3 did not have a code to ox for pain medication. E3 ow to call the after hours e. E3 acknowledged that est pain had not been now why E3 didn't chart the she had passed on in report Registered Nurse about cknowledged that R1's en notified about the chest n medication availability. In E13 RN, the employee care the day of 8/20/16, port about R1's chest pain I been reported to E13. E13 mplained of chest pain and E13 stated (R1) was very E13 stated that E13 was told edications in the building for t look in the narcotic box." t of R1's chest pain and as passed on in report to 14 Registered Nurse. E13 1's physician had not been st pain or pain medication.	F	309			

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DICAID SERVICES					APPROVED . 0938-0391
PROVIDER/SUPPLIER/CLIA	(X2) MULTI	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
IDENTIFICATION NUMBER:	A. BUILDIN	NG _			
146113	B. WING _				C 01/2016
		S	TREET ADDRESS, CITY, STATE, ZIP CODE	_	
		30	00 NORTH MARIETTA STREET		
		G	REENUP, IL 62428		
IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	x			(X5) COMPLETION DATE
14 RN, the employee the evening of 8/20/16, en from E13 about R1's ess and agitation. E14 sed after report and ed. E14 stated on khausted. R1 was asked "I hurt" and pointed to ain "I hurt." E14 stated it called because E14 ain from R1's right hip. pain medication after e access. E14 stated and R1 was able to pain and the physician was sent to the "sing Transfer/Discharge 6 at 6:35 pm documents to the local hospital. ospital records dated nents the following: "The patient ptoms 30 hours prior to rts that she received not evaluated while she " Emergency Room R1) 12-Lead (EKG) monstratesThis is ion Acute Myocardial vatient (R1) was started as medicated with 4 able aspirins. Troponin nt (R1) remained ous evaluations and her unfortunately with a arction " Hospital	F 3	309			
I dessort attaines approved on print of the second of the	A RN, the employee the evening of 8/20/16, en from E13 about R1's as and agitation. E14 aed after report and d. E14 stated on hausted. R1 was asked "I hurt" and pointed to in "I hurt." E14 stated called because E14 n from R1's right hip. bain medication after access. E14 stated and R1 was able to bain and the physician was sent to the sing Transfer/Discharge 5 at 6:35 pm documents the local hospital. espital records dated ents the following: "The patient toms 30 hours prior to as that she received ot evaluated while she Emergency Room 1) 12-Lead (EKG) nonstratesThis is on Acute Myocardial atient (R1) was started as medicated with 4 able aspirins. Troponin t (R1) remained us evaluations and her	DENTIFICATION NUMBER:       A. BUILDI         146113       B. WING         ENT OF DEFICIENCIES       ID         T BE PRECEDED BY FULL       PREFI         ENTIFYING INFORMATION)       TAG         4 RN, the employee       Preender         he evening of 8/20/16,       Fille         end after report and       E14         d. E14 stated on       hausted. R1 was asked         "I hurt" and pointed to       in "I hurt." E14 stated         called because E14       n from R1's right hip.         pain medication after       access. E14 stated         and R1 was able to       pain and the physician         was sent to the       Sing Transfer/Discharge         bat 6:35 pm documents       the local hospital.         rbm 30 hours prior to       ts that she received         ot evaluated while she       Emergency Room         1) 12-Lead (EKG)       nonstratesThis is         on Acute Myocardial       attent (R1) was started         attent (R1) was started       s medicated with 4         able aspirins. Troponin       t (R1) remained         us evaluations and her       unfortunately with a	DENTIFICATION NUMBER:       A. BUILDING         146113       B. WING         Image: Stress of the second stress of the	DENTIFICATION NUMBER:     A. BUILDING       146113     B. WING       300 NORTH MARIETTA STREET GREENUP, IL 62428       ENT OF DEFICIENCIES THE PRECEDENDE BY FULL ENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)       4 RN, the employee he evening of 8/20/16, in from E13 about R1's ss and agitation. E14 ed after report and d. E14 stated on hausted. R1 was asked 'I hurt' and pointed to in 'I hurt'. E14 stated called because E14 in from R1's right hip. Jain medication after access. E14 stated and R1 was able to Jain and the physician was sent to the       sing Transfer/Discharge 5 at 6.35 pm documents the local hospital.       sis matise received to evaluated while she Emergency Room 1) 12-Lead (EKG) honstratesThis is pm Acute Myocardial titent (R1) was started s evaluations and her unfortunately with a	DENTIFICATION NUMBER:     A BUILDING     COMP       146113     B. WING     09/       146113     B. WING     09/       STREET ADDRESS, CITY, STATE, ZIP CODE     300 NORTH MARIETTA STREET       ORDENUP, IL 62428     PROVIDERS PLAN OF CORRECTION       THE PRECEDED BY FULL     PREFIX       THE PRECEDED BY FULL     PREFIX       CROSS-REFERENCE TO THE APPROPRIATE     DEFICIENCY)       A RN, the employee     F 309       A RN, the employee     F 309       A RN, the amployee     F 309       A RN AT A stated on     Ansusted. R1 was asked       Th urf and pointed to     F 309       In The Transfer/Discharge     F 305       S at 6:35 pm documents     F 300       Inter Cords dated     F 300       ents the following:     F 300       The patient     F 300       toms 20 hours prior to

Facility ID: IL6002307

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		146113	B. WING				C 101/2016
NAME OF P	ROVIDER OR SUPPLIER	-			STREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND REHAB & HEALTH	сс			300 NORTH MARIETTA STREET GREENUP, IL 62428		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	sent to a specialized I Specialized Hospital I document Cardiac Ca and Coronary Angiog Temporary Pacemake Coronary Artery Block and distal. On 8/24/16 at 1:35 pr Physician stated that staff would be to notif chest pain or discomf should have been not chest pain or discomf should have been not chest pain." On 8/25/16 at 9:40 ar Physician stated that emergency room, R1 <sup>1</sup> and R1 had ST elevar indication of a complet (MI) over a 24 hour pe delay in transport fror caused a delay in inte (death) could have be certainly has heart mu completed MI. Z3 stat horrific experience at On 8/25/16 at 8:00 ar in the hospital bed. R person, place and tim surroundings and was sequence of events th stated that R1 had stat after arriving at the low	6 document that R1 hest pain again and was hospital per ambulance. Reports dated 8/21/16 atherization: Left Heart Cath raphy, Left Ventriculography, er with findings of Right kage of 100%, stents to mid m Z1, Primary Care the expectation of facility y Z1 if a resident is having ort. Z1 stated "Absolutely I tified immediately of (R1's) m Z3, Emergency Room when R1 arrived in the 's Troponin levels were high tion on the EKG an eted myocardial infarction eriod. Z3 stated that the n the facility certainly ervention and morbidity een a result. Z3 stated R1 uscle damage from the ted "I believe (R1) had a that facility." m R1 was sitting up supine 1 was alert and oriented to us. R1 was aware of R1's	F	309	9		

Facility ID: IL6002307

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						M APPROVED
		MEDICAID SERVICES				0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			PLETED
		146113	B. WING			C /01/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	LAND REHAB & HEALTH			3	00 NORTH MARIETTA STREET	
COMBER				G	GREENUP, IL 62428	
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX TAG	· · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	DATE
			-		DEFICIENCY)	
F 309	light wasn't even worf help. I was hot and sy the hospital. The nurs that just because I wa did not mean I could R1 that E12 had othe R1 stated that E12 sh later and fixed the ca not receive any pain in the afternoon. R1 s all night and was up to out of the facility alive and stated "I was sca nightmare to me. I kn with my heart but no me feel like I was cra was talking about. Lik don't. I'm just glad to On 8/31/16 an Immed identified. The imme- began on 8/19/16 wh assess and treat R1 ' for over 21 hours resu infarction (heart attac was notified of the Im 8/31/16 at 1:25pm. The surveyor was ab review and interview following actions to re 1. Nurses will or hav Corporate Administrator Prevention Policy (inc prevention), obtaining	g R1. R1 stated "my call king and I had to yell for weaty and wanted to go to se E12 told me very hatefully anted to go to the hospital go. R1 stated that E12 told or residents to take care of. hut the door and came back Il light. R1 stated that R1 did medication until the next day stated that R1 did not sleep up praying that R1 would get e. R1 was tearful at this time irred for my life. It was a ew something was going on one would listen. They made zy and didn't know what I ke I had dementia and I be out of there and alive." diate Jeopardy was diate jeopardy situation en the facility failed to s complaints of chest pain ulting in a myocardial k) with heart damage. E1	F	309		

Facility ID: IL6002307

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		146113	B. WING				C 01/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CUMBERI	AND REHAB & HEALTH	ICC			00 NORTH MARIETTA STREET REENUP, IL 62428		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	are not readily access Policy of a resident's Cards and Care Path shortness of breath; F for resident emergence	ysician when medications sible; Physician Notification change in condition; Care s including chest pain and Physician order not required cy transport; and neglect with policies. Corporate	F	309			

Facility ID: IL6002307

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