STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003156	A. BUILDING: _____ B. WING _____	06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA REHAB & HEALTH CARE CTR	232 GIVEN STREET FLORA, IL 62839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violation: 300.610a) 300.1010h) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003156	A. BUILDING: _____ B. WING _____	06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA REHAB & HEALTH CARE CTR	232 GIVEN STREET FLORA, IL 62839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 1 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 following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003156	A. BUILDING: _____ B. WING _____	06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA REHAB & HEALTH CARE CTR	232 GIVEN STREET FLORA, IL 62839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 2 Based on observation, interview, and record review, the facility failed to assess a resident's pain, document the effectiveness of pain medication, notify the physician that pain medications were ineffective, and provide non pharmacological interventions to assist with pain relief for one (R1) of two residents reviewed for pain in the sample of 28. This failure resulted in psychosocial and physical harm as evidenced by R1 expressing that the pain was so severe that R1 wanted to die, of which the facility did not notify R1's physician. Findings include: On 06/15/21 at 11:12am, R1 was observed in her room laying on her bed. R1 was alert and oriented to self. R1 was moaning loudly and yelling "My leg hurts!" V14, Registered Nurse, stated she had just given R1 morphine about 20 minutes prior to try to manage R1's pain. V14 stated R1 has pain as a result of end stage Parkinson's disease. V14 stated R, at times, has pain that is difficult to manage. V14 stated additionally, R1 displays behaviors of yelling out. V14 stated at times she is not sure if R1 is in pain or is just acting out. V14 did not offer to reassess R1 or provide non pharmacological interventions to help reduce R1's pain. R1's Face Sheet documents a diagnosis of Parkinson's disease. R1's May 2021 Physicians Order Sheet (POS) documents a 05/08/21 order for "Comfort Care."R1's June 2021 Physicians Order Sheet documented a 06/07/21 an order for Morphine Sulfate 100 milligrams per 5 milliliters (ml), take 0.25ml, increase from every four hours to every two hours, as needed for pain.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003156	A. BUILDING: _____ B. WING _____	06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA REHAB & HEALTH CARE CTR	232 GIVEN STREET FLORA, IL 62839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 3 On 06/16/21 at 1:40pm, V19 and V20, both Certified Nursing Assistants, both stated R1 does not display acting out behaviors which could be confused with pain. Both stated when R1 is in pain, she can tell you. R1's 03/03/21 Minimum Data Set (MDS) documented a Brief Interview for Mental Status Score of 9, indicating R1 has moderate deficits in cognitive functioning. The same MDS documented, "Should a pain assessment interview be conducted? Yes. Pain presence and frequency: Hurting almost constantly within the past five days. Pain intensity: 6(0-10 scale)." On 06/17/21 at 11:21am, V10, Resident Care Coordinator/ Licensed Practical Nurse, stated the facility has contacted R1's physician numerous times about R1's unresolved pain, but they have not heard anything back. V10 was unable to provide the documentation to substantiate this. V10 stated staff should be checking R1's pain, at minimum, once every 8 hour shift. V10 stated R1 is receiving comfort care measures related to end stage Parkinson's Disease. R1's Nurses Note dated 06/12/21 stated, "Crying out, told CNA (Certified Nursing Assistant) it hurts, I want to die. Morphine given again (12:40 am) and again at (2:45am) because (R1) was still crying out." R1's June 2021 Pain Management Flow Sheet had no corresponding entry for that date to indicate the intensity of the pain, what interventions were utilized to try to manage it, and the effectiveness of these interventions. There was no documentation to indicate R1's physician had been notified of R1's verbalization of wanting to die. An 06/15/21 2:15am Nurses Note documented, "Lots of crying out between midnight shift and 2:00am, pain medicine given."	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003156	A. BUILDING: _____ B. WING _____	06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA REHAB & HEALTH CARE CTR	232 GIVEN STREET FLORA, IL 62839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 4 There was no corresponding entry on the above referenced Pain Management Flow Sheet on 06/15/21 to indicate the intensity of the pain, what interventions were utilized to try to manage it, and the effectiveness of these interventions. R1's June 2021 Pain Management Flow Sheet and Nurses Notes documented that there were zero days in which R1's pain was assessed each shift, and R1's pain was not assessed at all on 06/07/21, 06/09/21, 06/15/21, and 06/16/21. This flow sheet documented that on 06/14/21 at 3:15pm, R1 was "In pain all over, 10(0-10), crying and shaking "with the effectiveness listed as "Some better". There was no documentation as to what interventions were utilized. The corresponding MAR (Medication Administration Record) documented that R1 received Morphine at 3:15pm. The next entry on this form documented that on 06/14/21 at 6:00pm, R1 was still experiencing generalized pain at a level of 10, was crying and shaking, received pain medication, and the effectiveness was "Better." The corresponding MAR documented that R1 received morphine at 6:00pm. There is no corresponding documentation to indicate why R1 did not receive the pain medication when it could have been given at 5:15pm. There was no documentation to indicate R1's physician had been notified on the above referenced dates that R1 was continuing to experience pain in spite of the morphine dose being increased on 06/07/21. An 06/17/21 Nurses Note stated, "(R1's Physician) here today, assessed resident, (and) requested monitoring for pain...Continue current treatment." The facility's 12/07/17 Pain Prevention and Treatment Policy documented, "It is the facility's	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003156	A. BUILDING: _____ B. WING _____	06/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLORA REHAB & HEALTH CARE CTR	232 GIVEN STREET FLORA, IL 62839

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 5 policy to assess for, reduce the incidence of and the severity of pain in an effort to minimize further health problems, maximize ADL(Activities of Daily Living) functioning and enhance quality of life ...Assessment of pain will be completed with changes in the residents condition, self-reporting of pain, or evidence of behavioral cues indicative of the presence of pain and documented in the nurses notes or on the pain management flow sheet." The facility's undated Comfort Care Policy stated, "It is the policy of (the facility) to offer comfort care to residents when it has been determined by a consensus of the resident and/or the residents family, in consultation with the primary physician and staff caring for the resident, that further aggressive treatment will provide more of a burden to the resident than it will benefit him or her. Measures: 5) Assess for pain, nausea, shortness of breath, fear, and anxiety. Notify physician for appropriate orders." (B)	S9999		