

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/07/2019
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CUMBERLAND REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MARIETTA STREET GREENUP, IL 62428
-----------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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 Incident Report Investigation to Incident of 2/19/19/IL110059	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210 b) 300.1210 d) 6) 300.3240 a) 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. Section 300.1210 General Requirements for Nursing and Personal Care 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect	S9999	<p>Attachment A Statement of Licensure Violations</p>	

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

Electronically Signed

TITLE

(X6) DATE

03/28/19

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/07/2019
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CUMBERLAND REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MARIETTA STREET GREENUP, IL 62428
------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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	<p>Continued From page 1</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements were NOT MET as evidenced by:</p> <p>Based on record review and interview, the facility failed to supervise a resident (R1) while toileting. This failure resulted in R1 falling off the toilet and sustaining a brain bleed with scalp laceration. R1 is one of three residents reviewed for falls.</p> <p>Findings include:</p> <p>The Cumulative Diagnoses Report (current) for R1 includes the following diagnoses: Alzheimer's Disease, Arrhthmia, Cardiac Pacemaker, Dizziness, Fall Risk, and Near Syncope (light headedness).</p> <p>R1's Physician Order Sheet dated February 2019, documents an order for Xarelto (blood thinner), 20 milligrams, every evening.</p> <p>The Minimum Data Set (MDS) dated 1/3/19, documents R1 as being moderately cognitively impaired and needing extensive assistance with transfers and toileting. This same MDS documents R1 needing staff assistance for stabilizing when moving from a seated to standing position, and from surface to surface.</p> <p>R1's Care Plan dated (current), documents R1 needing supervision for care, and has fall risk factors that require monitoring, and interventions to reduce potential for self-injury.</p> <p>Nursing Notes dated 9/26/18, document R1 being</p>	S9999		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/07/2019
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CUMBERLAND REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MARIETTA STREET GREENUP, IL 62428
-----------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------

(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	<p>Continued From page 2</p> <p>a new admit, and a returning admit after falling at home, and being a permanent resident in the facility. Fall Risk assessments from 9/26/18 to 1/3/19 document R1 being high risk for falls.</p> <p>A facility Situation Background Assessment Recommendation (SBAR) dated 2/19/19 at 6:10 pm, documents a fall with abrasion to left shoulder, contusion, and laceration to left side of scalp above ear, and a skin tear to elbow. The pain evaluation (above same report) documents R1 complaining of left hip, rib, and shoulder pain. The left leg is documented as being turned outward. The SBAR summary is documented as, "R1 was lying on left side, bleeding from laceration to left side of scalp with hematoma forming, skin tears to left elbow, left hip and abrasion to left shoulder." Response from V3, Primary Care Physician, was an order to send R1 to the Emergency Room per ambulance.</p> <p>Local Emergency Room (ER) records dated 2/19/19 at 7:05 pm, document the following: "(R1) presents to ER from (facility) w/co (with complaints of) fall. EMS (Emergency Medical Service) states (R1) was using the toilet and fell, hitting head, landing on left shoulder and hip. Computerized Tomography Brain/Head - Impression: Bilateral cerebral convexity acute subdural hemorrhages, 7 millimeters (mm) on the left and 4 mm on the right and 2.3 mm acute subdural hemorrhage at the anterior left falx. LET (lidocaine-epinephrine-tetracaine) was applied to the 2 centimeter laceration to the occipital area and staples were applied." This same record documents R1 being transferred to an area trauma hospital due to R1's subdural hemorrhages and use of Xarelto (blood thinner) for follow-up.</p>	S9999		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6002307	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/07/2019
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CUMBERLAND REHAB & HEALTH CC	STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MARIETTA STREET GREENUP, IL 62428
------------------------------------------------------------------	-----------------------------------------------------------------------------------------

(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	<p>Continued From page 3</p> <p>On 3/7/19 at 11:05 am, V1(Administrator) stated R1 was sent to the local emergency room where a CT scan was done, and a brain bleed was diagnosed. R1 was then sent to the trauma hospital for follow-up. R1 was admitted with a brain bleed on 2/19/19 at the trauma hospital and readmitted to the facility on 2/23/19. V1 stated previous to the fall, V4, Certified Nursing Assistant, had sat R1 on the toilet that had a riser on it. V4's glove had gotten soiled, and the sink and gloves are outside the bathroom in the residents' room. V4 left R1 on the toilet unattended and retrieved fresh gloves. V4 then heard R1 fall. V1 acknowledged V4 could have used the call light for assistance, but didn't.</p> <p>On 3/7/19 at 10:40 am, V3 Primary Care Physician stated R1's head injury was caused by the fall from the toilet, and R1 should not have been left unattended on the toilet by V4. V3 acknowledged V4 should have used the call light, or placed gloves in the bathroom prior to toileting. V3 stated had V4 been in the bathroom with R1, V4 could have prevented or lessened the fall, thereby preventing R1's major injury.</p> <p>(A)</p>	S9999		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--