STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146113	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cumberland Rehab & Health CC	300 North Marietta Street Greenup, IL 62428

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 35347 Based on interview and record review, the facility failed to ensure complete and accurate controlled medication records. This failure has the potential to affect one resident (R1) of three reviewed for medications. Findings include: On 5/30/2024 at 10:41AM, V2 (Director of Nursing) reported recently auditing R1's pain medication (oxycodone) administration record and controlled medication count sheet and finding discrepancies between the records. V2 reported facility staff failed to accurately document on R1's controlled medication count sheet all doses administered to R1 as documented on R1's medication administration record. V2 reported facility staff also failed to accurately calculate remaining doses of R1's medication on R1's-controlled medication count sheet. R1's controlled medication count sheet (May 2024) documents four count corrections on 5/21/2024, a late entry for medication administered on 5/15/2024, and multiple calculation errors on 5/21/2024.

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.

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