

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145697	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Knox County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 800 North Market Street Knoxville, IL 61448	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision and implement resident-specific fall prevention interventions to prevent accidents/injuries for two (R48 and R92) of six residents reviewed for accidents and supervision in the sample of 106. These failures resulted in actual harm to R92 after a fall forward from the wheelchair sustaining a laceration requiring sutures Findings include:R92's admission record documents R92's medical diagnoses including dementia, metabolic encephalopathy, cognitive communication deficit, unsteadiness on feet, muscle wasting and atrophy, abnormalities of gait and mobility, ataxia, osteoarthritis, and anemia.R92's Physical Therapy Evaluation and Plan of Treatment, dated 1/31/26, documents R92 used a manual wheelchair for mobility, was dependent for wheelchair mobility and transfers, demonstrated severe impaired routine decision-making, was unable to consistently follow commands, has impaired bilateral lower extremity range of motion, had diagnoses of unsteadiness on feet and lack of coordination, and had a Mobility Function Score of 1 (indicating complete dependence or substantial/maximal assistance).R92's Minimum Data Set (MDS) assessment, dated 5/27/26, documents R92 has severe cognitive impairment, required extensive assistance/dependence with mobility and activities of daily living, and used a wheelchair and was dependent with wheelchair mobility.R92's fall risk assessment, dated 5/27/26, documented R92 was at high risk for falls, had a history of falls, uses a wheelchair, had impaired gait, and overestimates or forgets limits. R92's current care plan documented R92 was at risk for falls and injuries related to unsteady balance, impaired mobility, and requires staff assistance with ADLs (activities of daily living) with a goal to minimize the risk for falls and injury by staff intervention. Interventions included escorting R92 back to R92's wing after meals, transferring R92 to a recliner after eating, increasing rounding, use of an anti-roll back wheelchair device, assistance with ADLs, completion of fall risk assessments, monitoring for unsteady gait and balance, and therapies as ordered. This same care plan documented R92 required assistance with his physical mobility needs, including being dependent for wheelchair mobility and R92's main mode of locomotion was, other person propelled wheelchair. There was no documentation of an intervention directing staff to utilize wheelchair footrests during transport or address the resident's behavior of placing his feet on the floor while being transported prior to 7/13/2026. The care plan was revised following the incident on 7/13/26 to require footrests while R92 was in the wheelchair.On 7/28/26 at 2:25 PM, V11, Certified Nursing Assistant, stated footrests should be applied to the wheelchair and residents' feet should be on them prior to pushing them in a wheelchair because you never know when a resident will put their feet down creating a risk for a resident to fall. If they put their feet down when pushed, they're going to fall. We are trained to do this to prevent falls from happening.On 7/29/26 at 10:25 AM, V12, Licensed Practical Nurse, stated R92 drags his feet a lot when he is pushed in his wheelchair and R92 did not have foot pedals on (continued on next page)		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 145697
		If continuation sheet Page 1 of 2

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F 0689 Level of Harm - Actual harm Residents Affected - Few	consistently prior to 7/13/26. V12 stated residents are not routinely assessed for the need for foot pedals, instead, it is determined what residents need them based on what is going on with them. On 7/29/26 at 1:32 PM, V13/R92's Power of Attorney, stated R92 had footrests for his wheelchair that were on at times and off at times prior to him falling on 7/13/26. V13 stated R92 was good at putting his feet down on the floor and stopping the wheelchair suddenly when he was being pushed. V13 stated, I'm not surprised the fall happened like that and he has very fragile skin. A progress note, dated 7/13/26, documented, R92 was being propelled in his wheelchair with staff assistance from the dining room back to the wing R92's room is on when R92 put his feet down on the ground and went forward in the wheelchair. The note further documented staff tried to catch R92 before he hit the floor, but they were unsuccessful and R92 had a left-hand injury with moderate amount of blood. The facility's incident report, dated 7/13/26, documented R92 was being transported from the dining room to R92's wing by staff in a manual wheelchair when R92 placed his feet on the floor, causing the wheelchair to stop abruptly. Staff attempted to prevent the fall from the wheelchair to the floor but were unsuccessful. R92 fell forward from the wheelchair, sustaining a left-hand injury with significant bleeding. Emergency Medical Services transported R92 to the emergency department for evaluation and treatment. A witness statement by V26, Certified Nursing Assistant (CNA), dated 7/13/26, documented, I, (V26), was wheeling (R92) back to his wing when (R92) put his feet down on to the ground, making the wheelchair come to a sudden stop. (R92) fell forward and I (V26) attempted to catch him but I was unsuccessful. R92 fell to ground and I (V26) immediately yelled for help. The facility's final report submitted to the State Agency documented R92's left hand injury required emergency department treatment consisting of steri-strips, tissue adhesive, and 10 sutures. This same report documented the care plan was updated following the incident to include an intervention for fall prevention to require wheelchair footrests for R92 when up in the wheelchair. R92's emergency department provider note, dated 7/13/26, documented R92 presented to the emergency department for a fall with a laceration to the hand. This same provider note documented R92 had a laceration to R92's dorsal left hand that was 7 cm (centimeters) in length by 7 mm (millimeters) in depth requiring extensive cleaning prior to complex closure with steri-strips around the wound, tissue adhesive to the steri-strips, and seven simple sutures. On 7/29/26 at 3:15 PM, V2, Director of Nursing, confirmed R92 should have had footrests on his wheelchair when V26, CNA, was propelling R92 in the wheelchair and if they were not. V2 further stated if the footrests were on then the fall could have been prevented.		