STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation & Health Center	107 North Watkins Street Cisne, IL 62823

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on interview and record review the facility failed to promptly notify the resident representative of a fall for 1 (R1) of 3 residents reviewed for notification of changes in a sample of 7. Findings Include: R1's Admission Record documented an admitted to the facility of 07/09/2024 with diagnoses including osteomyelitis, encounter for orthopedic aftercare, absence of left toes, chronic obstructive pulmonary disease, dementia, atrial fibrillation, heart failure, depression, and essential hypertension. R1's MDS (Minimum Data Set) with an Assessment Reference date of 08/08/2024, documented as a quarterly assessment, documented a Brief Interview for Mental Status (BIMS) Score of 13, indicating R1 is cognitively intact. A Skilled Progress Note for R1 dated 10/05/2024 , authored by V2 (Director of Nursing), documented on 10/06/2024 at 2:30 A.M. R1 had a fall in the bathroom and that the day shift nurse would notify POA (Power of Attorney) of the incident due to non-emergent situation and being early in the morning. R1's (Name of Company) Quality Care Reporting Form under the section titled Responsible Party Notified it is documented as son with no date or time documented on the form. On 11/20/2024 at 8:39 A.M., V3 (Registered Nurse) stated on 10/06/2024 when she got shift report from V2 (Director of Nursing), V3 was informed that R1 had had a fall in the bathroom and hit his head. The fall caused him to have a scratch on his head that bled. V3 stated that V2 was going to finish all the paperwork and call the POA (Power of Attorney). V3 stated that she completed her shift and once she was home, she received a text message from V2 stating that she had forgotten to call the POA for R1 to notify them of a fall. V3 stated that it was her understanding from shift report that V2 was going to call and notify the POA. V3 stated that she doesn't think the family had ever been notified of the fall form 10/06/2024. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

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Cisne Rehabilitation & Health Center	107 North Watkins Street Cisne, IL 62823

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/2024 at 10:07 A.M., V2 (Director of Nursing) stated that R1 fell off the toilet and hit his forehead. V2 stated that she gave report to V3 and let her know about the fall and that she would attempt to make all notifications prior to V2 leaving. V2 stated that before she left, she verbally told V3 that she had not called the POA and asked her to do so. V2 stated that she then wrote on the 24-hour report to call the POA regarding R1's fall. V2 stated that she sent V3 a text later in the day on 10/06/2024 apologizing for V3 having to make notifications for her. V2 stated that several days after the fall she heard a rumor that V3 was telling other nursing staff that she didn't call the POA of R1 because it was V2's responsibility. V2 stated at this point she spoke to V1 (Administrator) about the concern of R1's POA not being notified. V2 stated that R1's family was in the facility one day and she notified them then. V2 stated she did not chart that she had done it and she also does not remember the day she talked to R1's POA. V2 stated that it is her expectation for staff to notify the POA's of a resident fall as soon as possible. V2 stated that it has been a facility policy for staff to wait until later in the morning to notify family of a fall if it occurs in the middle of the night or early morning hours. On 11/22/2024 at 12:40 P.M., V1 stated he was unaware that the POA was not notified on R1's fall until it was brought to his attention by V3. V1 stated that it was his understanding the V3 was supposed to call the POA because V2 had asked her to do it before she left the faciity on [DATE]. V1 stated that it is his expectation for staff to notify POA's of any type of change as soon as possible. The facility policy titled Accidents and Incidents with a revision date of 09/06/2023 documents, Responsibility: It is the responsibility of the charge nurse to complete the incident report, notify attending physician, and responsible parties and document information accordingly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on interview and record review, the facility failed to protect and safeguard controlled substances for 1 (R1) of 3 residents reviewed for misappropriation of property in the sample of 7. Findings Include: R1's Admission Record documented an admitted to the facility of [DATE] with diagnoses including osteomyelitis, encounter for orthopedic aftercare, absence of left toes, chronic obstructive pulmonary disease, dementia, atrial fibrillation, heart failure, depression, and essential hypertension. R1's MDS (Minimum Data Set) with an Assessment Reference date of [DATE], documented as a quarterly assessment, documented a Brief Interview for Mental Status (BIMS) Score of 13, indicating R1 is cognitively intact. R1's Order Summary Report with a print date of [DATE] documented an order for Hydrocodone ,d+[DATE] mg (milligram), 1 tablet by mouth every 4 hours as needed for chronic pain with an order date of [DATE]. R1's Controlled Drug Administration Record documented that 24 Hydrocodone were received on [DATE] by V17 (Licensed Practical Nurse). The same form also documented R1 received Hydrocodone on [DATE] and [DATE] at 11:00 P.M. and was signed off by V11 (Licensed Practical Nurse) with 22 tablets remaining. On [DATE] V1 (Administrator) and V2 (Director of Nursing) were unable to produce the Controlled Drug Administration Record for the deliveries of Hydrocodone that were delivered on [DATE], [DATE], and [DATE]. R1's [DATE] MAR (Medication Administration Record) documented no doses of Hydrocodone were given on [DATE] or [DATE]. R1's Progress Note dated [DATE] and timed 12:54 P.M. documented, Upon doing narc (narcotic) count with (V11 Licensed Practical Nurse) this morning at 6:30am, which was correct, I noticed (R1's) slot for his as needed Hydrocodone was empty. I checked with electronic medical record following the discovery to verify the medication had not been discontinued. I then viewed the DON (Director of Nursing) box for recent narc count papers that may have been pulled, and also checked the destruction log. No narc count papers, or documentation of destruction of this medication was noted. Administrator was notified of this issue around 7am this morning. DON (V1) was notified as well. A facility incident report titled IDPH (Illinois Department of Public Health) Notification Form documented on [DATE] staff reported an allegation of misappropriation of resident property. Investigation initiated and follow up will be sent within 5 days. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A pharmacy delivery slip dated [DATE] documented R1 had 5 Hydrocodone delivered to the facility and signed by V18 (Licensed Practical Nurse) at 11:39 P.M. A pharmacy delivery slip dated [DATE] documented that R1 had 24 Hydrocodone delivered to the facility and signed by V4 (Registered Nurse) at 11:43 A.M. A pharmacy delivery slip dated [DATE] documented that R1 had 24 Hydrocodone delivered to the facility and signed by V17 at 8:13 P.M. A pharmacy delivery slip dated [DATE] documented that R1 had 24 Hydrocodone delivered to the facility and signed by V17 at 11:16 P.M. On [DATE] at 12:06 P.M., V7 (Pharmacy Operator) stated that R1 had Hydrocodone delivered to the facility on [DATE]. V7 stated that it was delivered at 11:16 P.M. and signed by V17 (Licensed Practical Nurse). On [DATE] at 8:39 A.M., V3 (Registered Nurse) stated that on [DATE] she was completing the narcotic count. V3 said she thought that it was weird that there was a slot for R1 and there was no cards or narcotic sign out sheet. V3 stated the facility does not count cards, they just count the pills that are on the card. V3 stated the count was accurate for all the cards that were present. V3 stated she looked in the electronic medical record and knew that R1 had an order for a narcotic. V3 stated she looked on the destruction log and then looked in the DON's box at the nurses station and did not find any sheets for R1's narcotic. V3 stated that she called V1(Administrator) around 7:00 A.M. to report the potential diversion. V3 stated she is not sure the last time she saw it in the cart. V3 stated that R1 never takes anything for pain. V3 stated that when she worked the night shift on [DATE], she thought there was some in there but cannot remember 100 percent. V3 said that V1 instructed her to call V6 (Registered Nurse) to see if she knew anything about it. V3 then called V6 and V6 told V3 that she didn't recall if R1 had any or not. V3 stated she called the pharmacy, and the pharmacy told her that the script expired the end of October and there was not a new one on file to fill. On [DATE] at 10:05 A.M. narcotic count was completed with V4 (Registered Nurse). The cards that were present had the correct number of medications on them matching the count sheets. There were not narcotics in the narcotic box for R1. On [DATE] at 12:00 P.M., V4 (Registered Nurse) stated that there is an order for R1 to have Hydrocodone but she never gives him any. V4 verified that there were no narcotics in the lock box for R1 and that there was no count sheet. V4 repeated she is unsure if R1 had any because she never gives him any. V4 did not recall the last time that there were narcotics in the locked box for R1. On [DATE] at 2:17 P.M., R1 was sitting in his recliner rolling around in his room. R1 stated that he has no pain. R1 stated that if he did he would tell the nurse and she will ask the doctor for something. R1 stated he does not know what medications he takes because he takes a hand full of them. R1 stated that he does not have pain and doesn't ask for any pain medication. On [DATE] at 10:00 A.M., V6 (Registered Nurse) stated she never gives R1 any pain medication. V6 stated that R1 never complains of pain and never appears to be in pain. V6 stated that she thought the order for R1's narcotic was discontinued after a hospital visit. V6 then checked the EMAR (Electronic Medication Administration Record) and noted that R1 has an order. V6 stated that she assumes that the medication was destroyed and is not sure where it is. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:07 A.M., V2 (Director of Nursing) stated she was off with COVID from [DATE]-[DATE]. V2 stated that V17 sent her a message on [DATE] about the narcotic sheet of R1 because V16 found it folded up under supplies in the bottom of the medication cart. V2 stated that when she returned on [DATE] she was working on investigating the diversion and the medication error. V2 stated that she had kind of forgot about it because she was so sick when she had COVID. V2 stated that she found the narc sheet yesterday in her office and it jogged her memory about it. V2 stated that it was reported to police, physician, POA (Power of Attorney) and IDPH (Illinois Department of Public Health) yesterday. V2 stated that when a card is empty the name sticker should be removed, and the card thrown away. V2 stated the narcotic count sheet is then placed in her mailbox for review and to store. V2 stated that she thought she had the Controlled Drug Administration Record for August, and she cannot find it. She thought it was on her desk in a red folder, but she cannot find it now. V2 stated that she keeps all the count sheets in her office in boxes but cannot find the ones for R1. V2 stated that V1 was starting the investigation and the facility had put different methods in place of counting to ensure nothing is being missed. V2 stated that the facility will now count the sheets, the cards and the medication to ensure the accuracy of all controlled substances. On [DATE] at 10:40 A.M., V1 (Administrator) stated he was notified on [DATE] that there could be a potential drug diversion. V1 stated that once her and V2 arrived to work on [DATE], they started investigating the diversion and the medication error. V1 stated that once the narcotic sign out sheet was found, they knew they had a big issue and reported it. On [DATE] at 9:45 A.M., V11 (Licensed Practical Nurse) stated that R1 is occasionally in pain due to having a toe amputation. V11 stated that he never asks for pain medication, but she will ask him because she knows with R1's diagnosis that he could be in pain. V11 stated she has asked the day shift nurses if they ever give R1 any pain medication and she got told they do not. V11 stated that she knows she has given the medication to R1, but she must not sign that it has been given on the MAR. V11 stated that there was a card in the narcotic box, and she wasn't sure the last time that she saw it. V11 stated that she could recall there were pills remaining on the far right of the card. V11 stated that she always does the narcotic count with the off going nurse. V11 stated the policy was to only count the number of pills, not the actual number of cards. V11 stated that she could have received narcotics from the pharmacy for R1 in the past but has not recently. V11 stated that when she receives narcotics, she counts them and puts them in the narcotic box. V11 stated the pharmacy deliveries usually come around 7:00 P.M. - 11:00 P.M. V11 stated that occasionally the pharmacy will deliver medications around 6:00 A.M., but it is usually in the evening / nighttime. V11 stated again that she is bad about signing off medications in the MAR but verifies times on the narcotic sheet to make sure it is not too soon. On [DATE] at 9:56 A.M., V12 (Licensed Practical Nurse) stated she works PRN (as needed) in the facility and has only worked three days since September being [DATE], [DATE], and [DATE]. V12 stated that the procedure for checking in narcotics, is the pharmacy will deliver, typically on night shift, and the nurse will verify the count is right and sign the delivery sheet and give it back to the pharmacist. Once it is checked in, V12 stated the narcotic sheet goes in the book and the card with the medicine goes in the locked narcotic box. V12 stated that when she gives as needed medications, she will sign the narcotic count sheet and the MAR that the medication was given. V12 stated that R1 has never complained of pain to her and she has never given R1 any as needed pain medication. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:26 A.M., V13 (Licensed Practical Nurse) stated she can't remember ever giving R1 and as needed pain medications. V13 stated she only works one day a week on Wednesday nights but had been off for vacation. Prior to working [DATE], V13 stated the last time she worked prior to that was [DATE]. V13 stated that she can't remember there being a card with medication on it for R1 at that time or not. V13 stated that when she gives as needed medications, she knows to sign out the MAR and the narcotic count sheet. V13 stated that typically if she receives a pharmacy delivery it is around 10 P.M. at night. V13 doesn't remember the last time that there was a delivery of narcotics for R1. V13 stated that she has been educated on the new way of signing in narcs and counting the cards not just the pills. On [DATE] at 11:31 A.M., V14 (Licensed Practical Nurse / Business Office Manager) stated that she will occasionally work the floor when there is a call in. V14 stated that she has worked partial shifts twice in the last couple weeks. V14 stated she has never given R1 any pain medications. V14 stated that R1 has never asked her or complained about pain when she was working. V14 stated that she always does the narcotic count but does not remember when R1 had narcotics in the drawer last. V14 stated that when she does give as needed medications, she will document it on the MAR and on the narcotic sheet. On [DATE] at 11:38 P.M., V15 (Licensed Practical Nurse) stated she is a full-time night shift nurse for the facility. V15 stated that she has never given R1 any as needed pain medication. V15 stated she does narcotic counts prior to starting her shift. V15 stated she has never known a count to be wrong. V15 stated she never realized that the card was missing for R1. V15 stated that she does remember there being narcotics in the locked box for R1 but is unsure when the last time they were there. V15 stated that she never counted the cards, she would just always count the pills. On [DATE] at 11:54 A.M. V17 (Licensed Practical Nurse) stated she was working her shift on [DATE]. It was after midnight, and she started cleaning the medication cart. It was about 12:20 am on [DATE] that she was cleaning the bottom drawer and noted R1's pink narcotic sheet folded and under some dividers. V17 stated that she then took a picture and notified V2. V17 stated that V2 asked her to verify if the order was still active in the computer and to see if there was a card in the narcotic box. V17 stated that she checked, and the order was active in the computer for R1. V17 then stated she checked the narcotic box and there was not a card for R1's Hydrocodone. V17 stated that she then placed the narcotic sheet in V2's box for review. V17 stated she has given R1 pain medication before, but it has been several months. V17 stated that she left for vacation on [DATE] and the card was in the narcotic box then. V17 stated that she was not good about charting on the MAR when she did give R1 pain medication, but she would always document it on the narcotic count sheet. A Final Incident Report received by IDPH dated [DATE] documented Based on the results of the investigation, the facility has found no evidence to support abuse. The facility has determined the 22 Norco were probably accidentally thrown away due to disorganization and lack of attention. The facility has determined V11 administered Norco to R1 on ,d+[DATE] and after that administration, the card was accidentally thrown in the trash. Ms. V18 supports this by confirming she didn't count the Norco on [DATE]. The facility has contacted pharmacy and instructed pharmacy to bill the facility for any unaccounted-for Norco. The facility has conducted an Ad Hoc QA meeting related to counting narcotic and narcotic management. All licensed staff were in-serviced on counting cards, count sheets and pills with appropriate sign off. DON or designee will conduct audits 3 times per week for 4 weeks to ensure compliance. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled (Name of Company) Abuse Prevention Program with a revision date of [DATE] documented , The facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property and exploitation .This facility therefore prohibits mistreatment, exploitation, neglect or abuse of its residents, and has attempted to establish a resident sensitive and secure environment. Under the section titled Definitions it documents Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49714 Based on interview and record review, the facility failed to report an allegation of misappropriation of resident property within the required time frames for 1 (R1) of 3 residents reviewed for misappropriation of property in the sample of 7. The Findings Include: R1's Admission Record documented an admitted to the facility of [DATE] with diagnoses including osteomyelitis, encounter for orthopedic aftercare, absence of left toes, chronic obstructive pulmonary disease, dementia, atrial fibrillation, heart failure, depression, and essential hypertension. R1's Order Summary Report with a print date of [DATE] documented an order for Hydrocodone ,d+[DATE] mg (milligram), 1 tablet by mouth every 4 hours as needed for chronic pain with an order date of [DATE]. A Progress Note dated [DATE], timed 12:54 P.M., authored by V3 (Registered Nurse) documented, Upon doing narc (narcotic) count with V11 (Licensed Practical Nurse) this morning at 6:30am, which was correct, I noticed R1's slot for his as needed Hydrocodone was empty. I checked with electronic medical record following the discovery to verify the medication had not been discontinued. I then viewed the DON (Director of Nursing) box for recent narc count papers that may have been pulled, and also checked the destruction log. No narc count papers, or documentation of destruction of this medication was noted. Administrator was notified of this issue around 7am this morning. I spoke with pharmacy regarding this medication, and they stated that they have not received any new orders, and previous order was last filled in August. DON was notified as well. On [DATE] at 8:39 A.M. V3 (Registered Nurse) stated that on [DATE] she was completing the narcotic count. V3 said she thought that it was weird that there was a slot for R1 and there was no cards or narcotic sign out sheet. V3 stated the facility does not count cards, they just count the pills that are on the card. V3 stated the count was accurate for all the cards that were present. V3 stated she looked in the electronic medical record and knew that R1 had an order for a narcotic. V3 stated she looked on the destruction log and then looked in the DON box and did not find any sheets for R1's narcotic. V3 stated that she called V1(Administrator) around 7:00 A.M. to report the potential diversion. V3 stated she is not sure the last time she saw it in the cart. V3 stated that R1 never takes anything for pain. V3 stated that when she worked the night shift, she thought there was some in there but cannot remember 100 percent. V3 said that V1 instructed her to call V6 (Registered Nurse) to see if she knew anything about it. V3 then called V6 and V6 told V3 that she didn't recall if R1 had any or not. V3 stated she called the pharmacy, and the pharmacy told her that the script expired the end of October and there was not a new one on file to fill. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:07 A.M. V2 (Director of Nursing) stated she was off during COVID from [DATE]-[DATE]. V2 stated V16 sent her a message on [DATE] about the narcotic sheet of R1 because V16 found it folded up under supplies in the bottom of the medication cart. V2 stated that when she returned on [DATE] she was working on investigating the diversion and the medication error. V2 stated that she had kind of forgot about it because she was so sick when she had COVID. V2 stated that she found the narc sheet yesterday in her office and it jogged her memory about it. V2 stated that it was reported to police, physician, POA (Power of Attorney) and IDPH (Illinois Department of Public Health) yesterday ([DATE]). V2 stated that V1 was starting the investigation and the facility had put different methods in place of counting to ensure nothing is being missed. V2 stated that the facility will now count the sheets, the cards and the medication to ensure the accuracy of all controlled substances. V2 stated she did not notify the admin at that time of a potential diversion. V2 stated that she was off with COVID when she was told by V17 about finding the narcortic slip in the bottom of the drawer. V2 stated V1 was off with COVID at the same time so she did not think there was anyone [NAME] who could do the investigation. V2 stated that once she came back to work on [DATE], she was working on other issues and forogt about the potential diversion. On [DATE] at 10:40 A.M. V1 (Administrator) stated he was notified on [DATE] that there could be a potential drug diversion. V1 stated that once her and V2 arrived to work on [DATE], they started investigating the diversion and the medication error. V1 stated that once the narcotic sign out sheet was found, they knew they had a big issue and reported it. An IDPH Notification Form documented on [DATE] staff reported an allegation of misappropriation of resident property. Investigation initiated, notification of physician, ombudsman and police done. Follow up will be sent within 5 days. The facility policy titled (Name of Company) Abuse Prevention Program with a revision date of [DATE] documented , Employees are required to immediately report any occurrences if potential/alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator. , Supervisors shall immediately inform the administrator of all reports of potential / alleged mistreatment. The same policy under the category External Reporting of Potential Abuse documents 1. Initial reporting of Allegations: The facility must ensure that all alleged violations involving mistreatment, exploitation, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The report must be made not later than 24 hours after forming the suspicion.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 49714 Based on interview and record review, the facility failed to timely initiate an investigate of an allegation of missing controlled substances for 1 of 3 residents (R1) reviewed for misappropriation of property in a sample of 7. Findings Include: R1's Admission Record documented an admitted to the facility of 07/09/2024 with diagnoses including osteomyelitis, encounter for orthopedic aftercare, absence of left toes, chronic obstructive pulmonary disease, dementia, atrial fibrillation, heart failure, depression, and essential hypertension. R1's MDS (Minimum Data Set) with an Assessment Reference date of 08/08/2024, documented as a quarterly assessment , documented a Brief Interview for Mental Status Score of 13, indicating that R1 is cognitively intact. R1's Order Summary Report with a print date of 11/22/2024 documented an order for Hydrocodone 5-325 mg (milligram), 1 tablet by mouth every 4 hours as needed for chronic pain with an order date of 10/29/2024. R1's Controlled Drug Administration Record documented that 24 Hydrocodone were received on 09/17/2024 by V17 (Licensed Practical Nurse). The same form also documented R1 received Hydrocodone on 11/01/2024 and 11/02/2024 at 11:00 P.M. and was signed off by V11 (Licensed Practical Nurse) with 22 tablets remaining. R1's November 2024 MAR (Medication Administration Record) documented no doses of Hydrocodone were given on 11/01/2024 or 11/02/2024. On 11/20/2024 at 8:39 A.M. V3 (Registered Nurse) stated that on 11/16/2024 she was completing the narcotic count. V3 said that she thought that it was weird that there was a slot for R1 and there was no cards or narcotic sign out sheet. V3 stated the facility does not count cards, they just count the pills that are on the card. V3 stated the count was accurate for all the cards that were present. V3 stated she looked in the electronic medical record and knew that R1 had an order for a narcotic. V3 stated she looked on the destruction log and then looked in the DON (Director of Nursing) box and did not find any sheets for R1's narcotic. V3 stated that she called V1 (Administrator) around 7:00 A.M. to report the potential diversion. V3 stated she is not sure the last time she saw it in the cart. V3 stated that R1 never takes anything for pain. V3 stated that when she worked the night shift, she thought there was some in there but cannot remember 100 percent. V1 instructed V3 to call V6 (Registered Nurse) to see if she knew anything about it. V3 then called V6 and V6 told V3 that she didn't recall if R1 had any or not. On 11/22/2024 at 9:55 A.M. V2 (Director of Nursing) stated that she was notified by V17 (Licensed Practical Nurse) on 11/12/2024 at 12:20 A.M. via text message that she found a narcotic sheet for R1 folded in the bottom of the medication cart under supplies. V2 stated she did not start investigating until she found the narcotic sheet on her desk 11/20/2024. V2 stated she was out with COVID which is why she did not immediately investigate it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024
NAME OF PROVIDER OR SUPPLIER: Cisne Rehabilitation & Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 107 North Watkins Street Cisne, IL 62823	

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/2024 at 10:40 A.M. V1 (Administrator) stated he was notified on 11/16/2024 that there could be a potential drug diversion. V1 stated that once he and V2 arrived to work on 11/18/2024, they started investigating the diversion and the medication error. V1 stated that once the narcotic sign out sheet was found on 11/20/2024, they knew they had a big issue and reported it. The facility policy titled (Name of Company) Abuse Prevention Program with a revision date of 11/28/2016 documented, Supervisors shall immediately inform the administrator of all reports of potential / alleged mistreatment, exploitation, neglect, and abuse of residents and misappropriation of resident property. Upon learning of the report, the administrator or designee shall initiate an investigation.

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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. 49714 Based on interview, observation, and record review the facility failed to account for, maintain records of, and document the administration of controlled substances for two (R1 and R3) of three residents reviewed for pharmacy services in the sample of 7. Findings Include: 1. R1's Admission Record documented an admitted to the facility of 07/09/2024 with diagnoses including osteomyelitis, encounter for orthopedic aftercare, absence of left toes, chronic obstructive pulmonary disease, dementia, atrial fibrillation, heart failure, depression, and essential hypertension. R1's MDS (Minimum Data Set) with an Assessment Reference date of 08/08/2024, documented as a quarterly assessment, documented a Brief Interview for Mental Status (BIMS) Score of 13, indicating R1 is cognitively intact. R1's Order Summary Report with a print date of 11/22/2024 documented an order dated 10/29/2024 for Hydrocodone 5-325 mg (milligram), 1 tablet by mouth every 4 hours as needed for chronic pain. R1's Controlled Drug Administration Record documented that 24 Hydrocodone were received on 09/17/2024. The same form also documented R1 received Hydrocodone on 11/01/2024 and 11/02/2024 at 11:00 P.M. and was signed off by V11 (Licensed Practical Nurse) with 22 tablets remaining. On 11/27/2024 V1 and V2 stated they were unable to produce the Controlled Drug Administration Record for the deliveries of Hydrocodone that were delivered on 08/06/2024, 08/14/2024, and 09/02/2024. R1's November 2024 MAR (Medication Administration Record) documented no doses of Hydrocodone were given on 11/01/2024 or 11/02/2024. R1's Progress Note dated 11/16/2024, timed 12:54 P.M., authored by V3 (Registered Nurse) documented, Upon doing narc (narcotic) count with (V11 Licensed Practical Nurse) this morning at 6:30am, which was correct, I noticed (R1's) slot for his as needed Hydrocodone was empty. I checked with electronic medical record following the discovery to verify the medication had not been discontinued. I then viewed the DON (Director of Nursing) box for recent narc count papers that may have been pulled, and also checked the destruction log. No narc count papers, or documentation of destruction of this medication was noted. Administrator was notified of this issue around 7am this morning. DON (V2) was notified as well. A pharmacy delivery slip dated 08/06/2024 documented R1 had 5 Hydrocodone delivered to the facility and signed by V18 (Licensed Practical Nurse) at 11:39 P.M. A pharmacy delivery slip dated 08/14/2024 documented that R1 had 24 Hydrocodone delivered to the facility and signed by V4 (Registered Nurse) at 11:43 A.M. A pharmacy delivery slip dated 09/02/2024 documented that R1 had 24 Hydrocodone delivered to the facility and signed by V17 at 8:13 P.M. A pharmacy delivery slip dated 09/17/2024 documented that R1 had 24 Hydrocodone delivered to the facility and signed by V17 at 11:16 P.M. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/2024 at 10:05 A.M. narcotic count was completed with V4 (Registered Nurse). There were not narcotics in the narcotic box for R1 and there were no count sheets in the narcotic book for R1. On 11/20/2024 at 12:00 P.M., V4 (Registered Nurse) stated that there is an order for R1 to have Hydrocodone but she never gives him any. V4 verified that there were no narcotics in the lock box for R1 and that there was no count sheet. V4 kept repeating she is unsure if R1 had any because she never gives him any. V4 did not recall the last time that there were narcotics in the locked box for R1. On 11/21/2024 at 10:00 A.M., V6 (Registered Nurse) stated she never gives R1 any pain medication. V6 stated that R1 never complains of pain and never appears to be in pain. V6 stated that she thought the order for R1's narcotic was discontinued after a hospital visit. V6 then checked the EMAR (Electronic Medication Administration Record) and noted that R1 has an order. V6 stated that she assumes that the medication was destroyed and is not sure where it is. On 11/22/2024 at 9:45 A.M., V11 (Licensed Practical Nurse) stated that R1 is occasionally in pain due to having a toe amputation. V11 stated that he never asks for pain medication, but she will ask him because she knows with R1's diagnosis that he could be in pain. V11 stated she has asked the day shift nurses if they ever give R1 any pain medication and she got told they do not. V11 stated that she knows she has given the medication to R1, but she must not sign that it has been given on the MAR. V11 stated that there was a card in the narcotic box, and she wasn't sure the last time that she saw it. V11 stated that she could recall there were pills remaining on the far right of the card. V11 stated that she always does the narcotic count with the off going nurse. V11 stated the policy was to only count the number of pills, not the actual number of cards. V11 stated that she could have received narcotics from the pharmacy for R1 in the past but has not recently. V11 stated that when she receives narcotics, she counts them and puts them in the narcotic box. V11 stated the pharmacy deliveries usually come around 7:00 P.M. - 11:00 P.M. V11 stated that occasionally the pharmacy will deliver medications around 6:00 A.M., but it is usually in the evening / nighttime. V11 stated again that she is bad about signing off medications in the MAR but verifies times on the narcotic sheet to make sure it is not too soon. On 11/22/2024 at 11:38 P.M., V15 (Licensed Practical Nurse) stated she is a full-time night shift nurse for the facility. V15 stated that she has never given R1 any as needed pain medication. V15 stated she does narcotic counts prior to starting her shift. V15 stated she has never known a count to be wrong. V15 stated she never realized that the card was missing for R1. V15 stated that she does remember there being narcotics in the locked box for R1 but is unsure when the last time they were there. V15 stated that she never counted the cards, she would just always count the pills. On 11/21/2024 at 10:07 A.M., V2 (Director of Nursing) stated it is her expectation for all nursing staff to count the narcotic box each shift with the off going nurse to ensure that the narcotic count for all residents are accurate. V2 stated that it is her expectation for licensed staff to not take, discard, or misuse the narcotics in the narcotic box. V2 stated that all staff should count the narcotics with the other nurse to make sure the counts are accurate. V2 stated that when a card is empty the name sticker should be removed, and the card thrown away. V2 stated the narcotic count sheet is then placed in her office mailbox for review and to store. V2 stated that she thought she had the Controlled Drug Administration Record for August, and she cannot find it. V2 said she thought it was on her desk in a red folder, but she cannot find it now. V2 stated that she keeps all the count sheets in her office in boxes but can not find the ones for R1. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R3's Admission Record documented an admitted to the facility of 08/06/2024 with diagnoses including nondisplaced comminuted fracture of shaft of humerus, atherosclerotic heart disease of native coronary artery, diastolic heart failure, essential hypertension, chronic atrial fibrillation, muscle weakness and hypothyroidism. R3's MDS (Minimum Data Set) with an Assessment Reference date of 11/13/2024, documented as a quarterly assessment, documented a Brief Interview for Mental Status (BIMS) Score of 08, indicating that R3 has moderate cognitive impairment. R3's Order Summary Report with a print date of 11/27/2024 documented an order dated 08/19/2024 for Hydrocodone 5-325 mg (milligram), 1 tablet by mouth every 6 hours as needed for pain. A pharmacy delivery slip dated 09/02/2024 documented R3 had 30 Hydrocodone delivered to the facility and signed by V18 at 8:13 P.M. On 11/27/2024 at 2:00 P.M., R3 stated she does not take her pain medicine as much as she was. R3 stated that she was taking it more frequently but as her broken bone is healing, she doesn't need it as often. R3 stated that if her pain gets bad, she knows she can ask the nurse and they will get her a pain pill. R3's September MAR (Medication Administration Record) documented on the back, R3 was given Hydrocodone on 09/03/2024 at 09:00 A.M., 09/06/2024 at 07:30 A.M., 09/07/2024 at 09:00 A.M, 09/09/2024 at 7:30 A.M., 09/10/2024 at 07:30 A.M., 09/13/2024 at 12:00 P.M., and 09/13/2024 at 3:30 P.M. On 11/27/2024 at 1:38 PM, a narcotic count was observed and completed by V4 (Registered Nurse). During the narcotic count it there was a card for R3 in the narcotic box with pills on it and there was a narcotic count sheet in the book for R3. On 11/27/2024 at 3:46P.M. V2 stated she cannot find the controlled drug count sheet that matches the delivery slip of 09/02/2024. V2 stated she will continue to look in her office as she knows she has it there. The facility policy titled Storage of Controlled Substances with an effective date of 09/2018 documented, 2. Schedule II through V medications and other medications subject to abuse or diversion are stored in either a permanently affixed, double locked compartment separate from all other medications. 4. A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule II, III, IV, and V medications, including those in emergency supply.5. A. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed personnel and is documented. 6. Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately and/ or in accordance with facility policy. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The Facility policy titled (Name of Company) Storage of Controlled Substances with a revision date of 08/2020 documented 8. Completed accountability sheets are submitted to the Director of Nursing and kept on file for five years at the facility in accordance with facility policy and state regulations. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled (Name of Company) Administrations Procedures for All Medications with a revision date of 08/2020 documented under section IV. Administration 7. After administration, return to cart, replace medication container (if multi dose and doses remain), and document the administration in the MAR or TAR (Treatment Administration Record) and the controlled substance sign out record.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 49714 Based on interview and record review the facility failed to ensure that residents are free from significant medication errors for 1 (R4) of 3 residents reviewed for medication administration in the sample of 7. Findings Include: R4's Admission Record documented an admitted to the facility of 04/14/2023 with diagnoses including unspecified dementia, acute cystitis, gastro-esophageal reflux disease, essential hypertension, insomnia, mixed hyperlipidemia, major depressive disorder, generalized anxiety and delusional disorders. R4's Order Summary Report with a printed date of 11/22/2024, with an order date of 10/29/2024 documented an order for Clonazepam (benzodiazepine) 0.5 mg (Milligram) by mouth two times a day . R4's (Name of Pharmacy) Controlled Drug Administration Record documented on 11/08/2024 that R4 was administered Clonazepam at 5:00 A.M. by V15 (Licensed Practical Nurse) 6:00 P.M., by V14 (Licensed Practical Nurse) and 8:00 P.M. by V11 (Licensed Practical Nurse). On 11/09/2024 R4 was administered Clonazepam at 5:00 A.M. by V11, 6:00 P.M. by V3 (Registered Nurse) and at 8:00 P.M. by V11. On 11/15/2024 R4 was administered Clonazepam at 5:00 A.M. by V3, 6:00 P.M. by V6 (Registered Nurse) and at 8:00 P.M. by V11. On 11/16/2024 R4 was administered Clonazepam at 8:00 A.M. by V11, 6:00 P.M. by V13 and 8:00 P.M. by V11. R4's November 2024 Medication Administration Record documented that R4 received Clonazepam twice daily at 08:00 A.M. and 6:00 P.M. The 4 additional doses that were administered by V11 were not documented in the electronic medication administration record (eMAR). R4's Progress Note dated 11/16/2024 authored by V3 (Registered Nurse) documented Notified Administrator (V1) and Director of Nursing (V2) of potential issues with electronic medical record and Clonazepam script. (V1) requested for me to leave note under door to remind him to further investigate on 11/18/2024. (V2) stated that she would check to see if she can figure out what is going on. R4's Progress Note dated 11/21/2024 with a time of 6:04 P.M authored by V2 documented Investigation into possible medication error initiated by myself (V2), and after investigation completion it was found and determined that this resident (R4) had been given her Clonazepam at 5:00 P.M. and then again by (V11 Licensed Practical Nurse) at 8:00 P.M. and a medication error had occurred. This nurse went down and spoke to resident an assessed her condition at that time with no noted negative effects of duplicate medication being administered noted. V/S (vital signs) @ (at) this time resident baseline as well. Attempted to notify POA (Power of Attorney) of med error incident with no answer. Left message to return call to facility. Attempted to contact (V16 Nurse Practitioner) with no answer, NP (Nurse Practitioner) scheduled to come to facility on 11/19/2024 and will notify her at that time if unable to reach prior to that time. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Progress Note dated 11/21/2024 with a time of 6:52 P.M. authored by V2 documented Late entry 11/20/24. Follow up on medication error. On 11/19/24 at approximately 1:00 P.M. I (V2) spoke with (V16-Nurse Practitioner) while she was present in the facility and notified her of the medication error that had occurred. (V16) stated she had assessed this patient (R4) and did not see any S/S (signs and symptoms) of any adverse reactions or harm that may have been caused by this error occurring. Then stated to monitor her for the remainder of the current day and if no ADR (Adverse Drug Reaction) noted still then may discontinue. A document title (Name of Company) Quality Care Reporting Form with a date of 11/19/2024 documented the nurse on duty on 11/16/2024, noticed a medication error for R4. R4 had received additional doses of Clonazepam due to going from paper MAR (Medication Administration Record) to electronic and the times were changed. This document stated Nurse failed to follow the electronic MAR causing the medication error. On 11/20/2024 at 8:39 A.M., V3 (Registered Nurse) stated that she discovered that R4 was getting her Clonazepam incorrectly. V3 stated that since going to the EMR (Electronic Medical Record), the times changed and the night nurse V11 was not giving the medications as per the MAR. V3 said that V11 was going ahead and giving R4 another dose of Clonazepam at 8 P.M. even though V3 had given it at 5 P.M. V3 stated on 11/16/2024 she notified V1 and V2 of the medication error and was told they will look into it on 11/18/2024. On 11/21/2024 at 10:07 A.M., V2 (Director of Nursing) stated that she was out with COVID when she was notified of the potential of a medication error. V2 stated that she was notified on 11/16/2024 that there was a potential medication error. V2 said that V3 notified her of the potential medication error. V2 stated that she started the investigation on the medication error on 11/18/2024. V2 stated that she notified the physician on 11/19/2024 as she confirmed that there was an issue. V2 stated that when the facility went live with EMAR (Electronic Medication Administration Record), the times were changed on R4's Clonazepam. V2 stated that the nurse was not looking at the EMAR, she was just signing it off like she had done for the last two years. V2 stated that she notified the physician, and then tried to notify the family. V2 stated that she left messages for the POA (Power of Attorney), and they have not returned her call. R4 received extra doses of Clonazepam on 11/8/24, 11/09/24, 11/15/24 and 11/16/24. V2 stated that there were no ill side effects to R4 for receiving the extra medications. On 11/21/2024 at 10:40 A.M., V1 (Administrator) stated that he was unaware of the medication error until V3 notified him. V1 stated at that point it was a possible medication error and V2 was going to investigate it. V1 stated that V2 talked with the nurse in question and notified V16. On 11/22/2024 at 9:45 A.M., V11 (Licensed Practical Nurse) stated she was the nurse who gave the extra doses of Clonazepam to R4. V11 stated that she was unaware that the time had changed on the MAR, and she was simply giving it like she always had. V11 stated I have to accept responsibility for this because I did not look at the MAR before giving the medication, I gave it according to my memory. V11 stated that R4 was already in bed when she gave it, and she doesn't get up at night. V11 stated that she did not notice any ill effects to R4 on the 4 nights it was given. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Medication Administration Policy / Procedure with a revision date of 09/27/2022 documented, Medications will be administered safely to residents within the facility by licensed nurses at the specified time/time frame, following the recommended administration method and will be documented as required.