STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to timely treat and develop/implement interventions for a pressure ulcer for 1 (R1) of 3 residents reviewed for pressure ulcers in the sample of 4. This failure resulted in R1's pressure ulcer worsening, with tunneling and developing an infection in the wound. The Findings Include:R1 admission Record documented admission to the facility on [DATE] and included diagnoses of heart failure, thrombocytopenia, depression, anxiety, obstructive sleep apnea, personal history of malignant neoplasm of thyroid, and lymphedema. R1's Minimum Data Set (MDS) assessment dated [DATE] and coded as an admission assessment documents R1 has a Brief Interview for Mental Status (BIMS) score of 07, indicating R1 has severe cognitive impairment. The MDS documents R1 is frequently incontinent of bowel and bladder, and further documents R1 has a stage 2 pressure ulcer. The MDS section for Functional Goals and Abilities documents R1 is dependent for personal and toileting hygiene. The MDS section for Skin Conditions documents R1 has one Stage 2 pressure ulcer that was present upon admission. Under Skin and Ulcer/Injury Treatment, the following are checked: Pressure reducing device for chair, Pressure ulcer/injury care, Application of nonsurgical dressings, and Applications of ointments/medications. R1's Order Summary Report documents an active order dated 4/13/26 for ENHANCED BARRIER PRECAUTIONS: (wounds) with dressing, bathing, transfers, changing linens, providing hygiene, toileting or pericare, device care, or wound care every shift. The Order Summary Report also documented active orders for (Wound Care Company) to consult for skin assessment andwound care as needed and for (Wound Care Company) to eval and treat dated 04/13/26. R1's April Treatment Administration Record documents an order to cleanse wounds on buttocks and coccyx with normal saline q (every) shift and apply medi honey and cover with bandage every shift for pressure ulcers with a start date of 4/13/26 and discontinued date of 4/15/26. R1's Electronic Health Record (EHR) contains a treatment order dated 4/15/26 documenting: TREATMENT - Cleanse wounds on buttocks and coccyx with normal saline and apply medi honey and cover with dry dressing every day shift for pressure ulcers. There are no orders noted in R1's EHR or Order Summary Report documenting a treatment to pack the tunneling to R1's wound. R1's Care Plan documents no Focus areas or interventions related to skin integrity, pressure wounds, or Enhanced Barrier Precautions prior to 5/13/26. R1's Care Plan documents an added Focus area of the resident has actual impairment to skin integrity related to buttock and coccyx pressure wound (initiated 05/13/26). Corresponding interventions include: Administer treatments as ordered and monitor for effectiveness, avoid shearing while repositioning in bed, document location of wound, size, amount of drainage, peri-wound area, pain, edema, and circumference measurements weekly and as needed, educate resident/family/caregivers of causative factors and measures to prevent skin injury, monitor dressing when providing care to ensure it is intact and adhering. Report lose [sic] dressing to nurse, monitor pressure areas for changes in color, sensation, temperature, and report any change to nurse, referral to wound specialist, wound culture results came in with ESBL (Extended-Spectrum Beta-Lactamase)/ECOLI (Escherichia coli). All interventions for this focus area were documented to be initiated on 05/13/26. R1's Care Plan also documents an added Focus area of the resident is on enhanced barrier precautions (EBP) related to pressure wound (initiated 05/13/26). (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	Corresponding interventions include: Direct care staff and visitors to follow EBP, direct care staff to utilize gowns and gloves for all personal care, educate resident, responsible party, and direct care staff on EBP, monitor resident for signs and symptoms of infection. Document and properly report signs/symptoms of potential infections, monitor residents psychosocial and mental well-being related to EBP. Document any changes and report any symptoms promptly, and provide support and allow resident to express feeling, fears, and concerns. All interventions for this focus area were documented to be initiated on 05/13/26. R1's Progress Notes document the following skin issues: Effective Date: 04/10/26 (authored by V20-Registered Nurse/RN) Type: Braden Scale for Predicting Pressure Ulcer Risk Evaluation LATE ENTRY Braden Evaluation: Sensory Perception: Slightly limited. Moisture: Occasionally moist. Activity: Walks occasionally. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Probably inadequate. Friction and shear: Problem. N Adv - BRADEN Score: 14.0 Actioned Clinical Suggestions:.Comments:. The space under Actioned Clinical Suggestions and Comments is blank. Effective Date: 04/12/26 (authored by V3/RN) Skin Issues: .New skin Issue. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 14 Width (cm): 18 Depth (cm): 1.2 Undermining: No. Tunneling: No. Epithelial: 20%. Granulation: 10%. Slough: 40%. Eschar: 0%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Odor after cleansing: None. Periwound: Attached. Surrounding tissue: Blanching. Induration: None present. Edema: No swelling or edema. Periwound temperature: Normal. Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 04/16/26 (authored by V2 -RN/Director of Nursing/DON): Skin Issues.Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 8 Width (cm): 11 Depth (cm): 0 Undermining: No. Tunneling: No. Odor after cleansing: None. Surrounding tissue: Erythema. Surrounding tissue: Blanching. Surrounding tissue: Fragile. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank.Effective Date: 04/17/26 (authored by V2 -RN/DON): Type: Braden Scale for Predicting Pressure Ulcer Risk Evaluation Braden Evaluation : Sensory Perception: Slightly limited. Moisture: Occasionally moist. Activity: Chairfast. Resident is Slightly Limited: Makes frequent though slight changes in body or extremity position independently. Nutrition: Adequate. Friction and shear: Potential problem. N Adv - BRADEN Score: 16.0 Actioned Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 4/19/26 (authored by V20/RN) LATE ENTRY Skin Issues:.Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer/injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 2 Pressure ulcer/injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Healthcare provider. Length (cm): 14 Width (cm): 18 Depth (cm): 1 Undermining: No. Tunneling: No. Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 04/24/26 (authored by V2/DON) Braden Evaluation: Sensory Perception: Slightly limited. Moisture: Occasionally moist. Activity: Chairfast. Resident is Slightly Limited: Makes frequent though slight changes in body or extremity position independently. Nutrition: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	Adequate. Friction and shear: Potential problem. N Adv - BRADEN Score: 16.0 Actioned Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 4/27/26 (authored by V21/RN) Skin Issues: Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Painful: No. Staged by: Health care provider. Length (cm): 8 Width (cm): 5 Depth (cm): 1.5 Undermining: No. Tunneling: No. Epithelial: 10%. Slough: 50%. Eschar: 20%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Odor after cleansing: Moderate. Periwound: Non-attached. Surrounding tissue: Denuded. Induration: Induration, < 2cm around wound. Edema: No swelling or edema. Periwound temperature: Normal. Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 04/29/26 7:26PM Type: Physician Progress Note (Authored by V4-Nurse Practitioner/NP) documents S/R (self reports) she (R1) is ok. S/R the wound on her bottom burns. Denies any current needs Admit History - Reason for admission for this Stay:(R1) in the long term care facility. She had a cerebral infarction but just has generalized weakness and is in a wheelchair. She is currently on aspirin. She has hypothyroidism and takes levothyroxine. She has a wound to her buttocks that has an odor so I ordered a woundculture. She has debility and is working with PT (Physical Therapy). Effective Date: 04/29/26 (authored by V22-Licensed Practical Nurse/LPN) Type: Health Status Note. Note Text: Received orders from V4 (NP) to obtain wound culture from buttocks to rule out infection. Effective Date: 4/30/26 (authored by V2-RN/DON) Skin Issues: Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 8.7 Width (cm): 8.4 Depth (cm): 0 Undermining: No. Tunneling: No. Odor after cleansing: None. Surrounding tissue: Normal in color. Surrounding tissue: Blanching. Surrounding tissue: Erythema. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing appearance: Saturated. Dressing saturation: Moderate 26-75% Completed Clinical Suggestions:.Comments: The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 04/30/26 (authored by V3/RN) documented lab here and the culture was sent with the lab tech (technician). No difficulties noted. Effective Date: 05/02/26 (authored by V22/LPN) documents Braden Evaluation: Sensory Perception: No impairment. Moisture: Very moist. Activity: Chairfast. Resident is Slightly Limited: Makes frequent though slight changes in body or extremity position independently. Nutrition: Adequate. Friction and shear: Potential problem. N Adv - BRADEN Score: 16.0 Actioned Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 05/03/26 (authored by V20/RN) LATE ENTRY Skin Issues: Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer/injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 2 Pressure ulcer/injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 8.7 Width (cm): 8.4 Depth (cm): 2.5 Undermining: No. Tunneling: No. Epithelial: 20%. Slough: 50%. Eschar: 20%. Exudate amount: Light. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Odor after cleansing: Moderate. Periwound: Non-attached. Surrounding tissue: Erythema. Surrounding tissue: Blanching. Surrounding tissue: Normal in color. Induration: Induration, < 2cm around wound. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Saturated. Dressing appearance: Intact. Dressing saturation: Moderate 26-75%. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective 05/06/26 (authored by V2-RN/DON) Skin Issues: Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 2 Pressure ulcer/injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Staged by: Health care provider. Length (cm): 8.4 Width (cm): 7.5 Depth (cm): 2.7 Undermining: No. Tunneling: No. Odor after cleansing: Faint. Surrounding tissue: Dark reddish brown. Surrounding tissue: Blanching. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Saturated. Dressing appearance: Intact. Dressing saturation: Minimal < 25%. Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. Effective Date: 05/06/26 at 10:04AM (authored by V3/RN) documented V4 (NP) was in the facility and assessed R1. New orders received. Effective Date 05/06/26 at 12:28PM Type: Physician Progress Note (authored by V4/NP) documents She (R1) has a wound to her buttocks. She has debility and is working with PT. Ordered Norco for pain and a wound consult.Wound: Chronic-stable ordered wound culture. Effective Date 05/06/26 at 5:36PM (authored by V3/RN) documented laboratory notified the facility that the wound culture for R1 had to be discarded due to the courier taking too long to send it off for results. New order received for new culture. Local Hospital Report dated 05/07/26 documented the laboratory received the culture on 05/07/26 at 8:24 PM. The report documented the culture was reported on 05/10/26 at 7:42 AM. R1's wound culture was noted to be growing Escherichia coli, ESBL, and Enterococcus Faecalis. Effective Date 05/08/26 (authored by V22/LPN) documented V4 (NP) was notified of lab results and would await sensitivity. Effective 05/13/26 (authored by V2-RN/DON) Skin Issues: Skin issue has been evaluated. Location: Coccyx. Additional location information: and buttocks Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound was present on admission. It is unknown how long the wound has been present. Signs and symptoms of infection: None. Painful: Yes. Wound pain (Frequency): Intermittent. Pain description: Sharp. Wound pain interventions: Change in position. Wound pain interventions: Relaxation techniques. Wound pain interventions: Medicate prior dressing change. Relief from interventions: Yes. Staged by: Health care provider. Length (cm): 7.5 Width (cm): 8 Depth (cm): 1.8 Undermining: No. Tunneling: No. Odor after cleansing: Faint. Surrounding tissue: Erythema. Surrounding tissue: Blanching. Edema: No swelling or edema. Periwound temperature: Normal. Dressing appearance: Intact. Dressing saturation: Minimal < 25%. Completed Clinical Suggestions:.Comments:. The space under Completed Clinical Suggestions and Comments is blank. On 05/13/26 at 8:30 AM, during a tour of the facility, R1's room was observed to not have any signage indicating R1 was on Enhanced Barrier Precautions or isolation. R1's room did not have a Personal Protective Equipment (PPE) station outside of the room. On 05/13/26 at 8:52 AM, V8 (CNA) was observed caring for R1 and stated she was completing a bed bath. V8 did not have PPE on at this time. On 05/13/26 at 10:42 AM, R2 stated she and R1 used to be roommates. R2 stated R1 was moved because R1's wound smelled really bad, and the facility did not think that it was fair to R2 to smell it. R2 stated the facility was doing a dressing to R1's wound but R2 feels like R1 needs to see a wound specialist. R2 stated R1 was incontinent of bowel and bladder and staff did not check on R1 every couple hours, especially on night shift. R2 said R1 would not be checked on all night, then right before shift change they would change her. R2 stated R1's bed would get soaked and the housekeeping staff would have to clean it every day. R2 stated while she and R1 were roommates, the staff were not turning or repositioning R1. R2 said she would hear staff tell R1 she needs to turn, but no staff would actually assist her. R2 stated she is fearful that R1's wound is only going to get worse. On 05/13/26 at 11:46 AM, R1 stated the wound to her butt hurts her really bad. R1 said the care is terrible and she feels helpless because her pain is bad and she is incontinent now and needs changed. R1 then attempted to sit and immediately laid back down saying she hurts too much. On (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	05/13/26 at 11:56 AM, V4 (NP) stated R1 was admitted with the wound that she has to her coccyx. V4 stated she has been managing the wound with Medihoney and it is improving. V4 stated R1 is being referred to wound care. On 05/13/26 at 2:20 PM, V2 (DON) stated R1 was admitted with a wound and there were no orders for wound care from the hospital. When questioned about the facility not having treatment orders in place until 4/13/26, V2 stated she was not aware that R1 went 3 days with no orders for a dressing change. V2 said believes the measurements on the 04/12/26 assessment (14cm x 18cm x 1.2cm by V3) are accurate. V2 stated she completed the measurements on 04/16/26 and believes those to be accurate (8cm x 11cm x 0). V2 stated the staff are not familiar with the wound program in the electronic health record and she was at a meeting which is why there are no pictures of R1's wound upon admission in the record. V2 stated she feels like the current treatment is doing ok and there is no need to change it. V2 stated they are looking into a surgical consult for R1 for debridement. V2 stated she is not sure why the wound is coded as a Stage 2, but she was considering it unstageable from admission. On 05/13/26 at 2:50 PM, when this surveyor asked about R1's culture results, V2 (DON) stated she was trying to get R1's wound culture results from the local hospital. V2 stated she is not sure why they do not have the culture back. V2 stated one of the nurses called to check on it and it was her understanding they were told there was nothing growing. The Order Summary Report documents a treatment order dated 05/13/26 (start date 5/14/26) to cleanse wounds on buttocks and coccyx with wound cleanser, apply Medihoney to slough and calcium alginate to granulated tissue, cover with dry dressing, initial and date every day shift for pressure ulcers. Effective 05/13/26 at 4:25 PM: (authored by V2-RN/DON) documented treatment order to coccyx changed to cleanse wounds on buttocks and coccyx with wound cleanser, apply Medihoney to slough and calcium alginate to granulated tissue, cover with dry dressing, initial and date, change daily and prn (as needed) for soiled/dislodged dressing per np. Wound culture results received and sent to V12 (Nurse Practitioner). New orders to start dicloxacillin 500mg (milligrams) po (by mouth) every 6 hours x (times) 7 days and bactrim ds 800-160 mg po every 12 hours x 7 days. On 05/13/26 at 3:59 PM, V2 presented R1's wound culture from the local hospital dated 05/07/26 to this surveyor, which showed the wound growing Escherichia coli, ESBL, and Enterococcus Faecalis. V2 stated she wasn't sure why she had to call to get the results, usually they come back, but the hospital did not fax them. V2 stated they are calling the doctor now to get an order for an antibiotic. On 05/14/26 at 5:05 AM, V5 (Licensed Practical Nurse/LPN) stated R1 was moved to a room last night because she had to be put on isolation precautions for an infection in her wound. V5 stated she was not sure if R1 was on enhanced barrier precautions. On 05/14/26 at 5:50 AM, V7 (CNA) was observed walking into R1's room. V7 uncovered R1 and looked at her adult incontinence brief. V7 did not have PPE on at this time. On 05/14/26 at 6:00 AM, V7 stated she was supposed to wear a gown when she went into R1's room but didn't. V7 stated she wasn't sure why she did not wear a gown but knows that R1 is on isolation. On 05/14/26 at 07:00 AM, R1 was alert to self and time. R1 recognized this surveyor from meeting the previous day. R1 knew V8 (Certified Nurse Assistant/CNA) by name at this time. V8 (CNA) donned PPE, entered R1's room, opened a pack of incontinence wipes and folded down R1's incontinence brief. V8 used the wipes to clean R1's peri area and discarded the wipes. V8 then rolled R1 over to her right side, grabbed another wet wipe from the package, and began wiping R1's coccyx area, which was soiled with stool. V8 discarded the wipe and pulled another one from the package using the same gloves. V8 cleaned R1's coccyx area that was soiled with stool, removed the soiled incontinence brief from R1's bed and threw it in the trash. V8 then discarded her gloves and applied new ones without performing hand hygiene. V8 placed a new brief on R1, then assisted R1 with dressing and assisted her to her wheelchair. V8 then disposed of her gloves and sanitized her hands. During this time, there was no old dressing observed to be on R1 and there was not a new dressing applied before R1 was dressed and taken to the dining room for breakfast. On 05/14/26 at 7:41 AM, V8 (CNA) stated she had been reporting to the nursing staff that R1's wound had a smell to it for a while. V8 stated she would notify the nurses of the changes in the wound, and nothing was being (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	done. V8 (CNA) stated R1 was not on isolation precautions of any kind on 05/13/2026. V8 stated R1 was placed on precautions last night after a wound culture came back. On 05/14/26 at 7:43 AM, V9 (CNA) stated she has reported wound issues/concerns to the nurse for weeks. V9 stated R1's wound had a terrible smell and she reported it to the nursing staff. V9 stated R1 was not on isolation yesterday. V9 stated R1 is on it today because of her wound culture. On 05/14/26 at 7:49 AM, V8 stated R1 does not have a wound dressing on a lot of the mornings that she provides care for her. V8 stated R1 is incontinent through the night so the dressing gets soiled, and no one puts a new one back on. On 05/14/26 at 8:07 AM, V6 (CNA) stated this morning, she completed peri care/bed check on R1 somewhere between 2:30 and 3:00 AM V6 stated at that time there was no dressing observed on R1's wound. V6 stated she made V5 (Licensed Practical Nurse/LPN) aware. On 05/14/26 at 8:58 AM, V3 (Registered Nurse/RN) stated R1 was not on Enhanced Barrier Precautions yesterday. V3 stated when R1's culture was faxed yesterday to the facility, R1 was moved to an isolation room. V3 stated R1 should have been on Enhanced Barrier Precautions for her wound. On 05/14/26 at 9:02 AM, V3 donned PPE and knocked on R1's door. V3 then explained to R1 that it was time to complete her dressing change. R1 was tearful and complained of pain at this time. V3 removed R1's pants and her incontinence brief was visibly soiled. V3 removed the tabs and pulled down the incontinence brief. R1 had been incontinent of urine. The wound was wet and had a large amount of serosanguinous drainage. V3 began to measure the wound without separating R1's buttock. When the surveyor questioned V3 about this, V3 stated he knows he has to hold the skin so the measurements are more accurate. There was no dressing observed on R1's wound at this time. V3 stated he wasn't aware R1's dressing was off. V3 measured the wound bed at 9.1cm long x 10.5cm wide x 2.8cm deep with tunneling observed at the 11 o'clock position and going up. V3 proceeded to complete the wound treatment, applied a new incontinence brief, and positioned R1 for comfort. On 05/14/26 at 11:48 AM, V2 (DON) stated R1 should have been on Enhanced Barrier Precautions related to her wound. V2 stated she thought R1 was on these precautions. V2 said for residents who meet criteria, it would be her expectation that they be on Enhanced Barrier Precautions. V2 stated there should have been signs on the door notifying staff about isolation. On 05/14/26 at 11:48 AM, V2 (DON) stated R1's wound was discussed with V12 (Nurse Practitioner) and she ordered the wound dressing to be changed after the culture came in. V2 stated V3 (RN) took the orders from V12 and V2 placed them in the computer because V3 was busy. V2 stated she was not aware that R1's wound had any drainage. V2 stated it could be the Medihoney draining. V2 stated she was not aware that R1's dressing was not on. V2 stated that she will educate the staff about making sure there is a dressing on all the time. On 05/14/26 at 5:38 PM, V3 (RN) stated the culture was first obtained on 04/30/2026 and sent with the lab courier. V3 stated he was notified on 05/06/2026 that the courier had not delivered the culture to the lab and a new one would be needed. On 05/15/26 at 8:45 AM, V5 (LPN) stated she was not aware that R1's dressing was not in place on 05/14/26. V5 stated if the staff had told her, she would have applied a new dressing. V5 stated she is unsure how long the dressing was off. On 05/15/26 at 9:15 AM, V2 (DON) stated R1's culture was completed on 04/30/26 and the lab courier took it. V2 stated no one from the facility followed up on the culture, and the lab notified the facility on 05/06/26 that the specimen was not received in time to be processed. V2 stated they immediately obtained another culture and sent it to a local hospital for processing. V2 stated the nurses should have been following up on the first one and the second one to make sure they got the results in a timely manner. V2 stated the lab never sent a sheet that said the culture could not be processed. V2 stated the order from 04/13/26 for R1 to see wound care was part of an order set and explained these were orders the nurses just click on as part of the admission. V2 stated on 05/06/2026 the facility obtained an order for R1 to see a wound care provider. V2 stated that R1 has an appointment with a wound care provider on 05/20/26. V2 stated she believes that the treatment the facility has been using was working. V2 stated she feels Medihoney was the best treatment for the slough area. V2 said that tunneling is treated with packing, but they are not doing that. V2 said she is not sure why the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0686 Level of Harm - Actual harm Residents Affected - Few	measurements that were taken on 05/13/26 (7.5cm x 8cm x 1.8) are so different than the measurements that were taken on 05/14/26 (9.1cm x 10.5cm x 2.8cm). V2 stated she is not sure why there are so many inconsistences with the measurements. V2 stated moving forward V3 is the only nurse who will be completing the measurements weekly. V2 stated R1 was admitted on a Friday night (4/10/26) and the nurses failed to get a treatment order. V2 said when she came in the following Monday (4/13/26) she reviewed R1's admission and realized that it was not completed. V2 stated she isn't sure when V4 (NP) saw R1's wound last but V4 was supposed to look at it this week. V2 said the facility ordered a low air loss mattress for R1 today. V2 said that R1 moves around so much she didn't think about R1 needing a different mattress. On 05/15/26 at 10:19 AM, V15 (Medical Director) stated he is not familiar with R1 and believes V17 (Physician) is following R1. V15 stated V4 (NP) is who regularly sees R1, and he would have to talk to her in order to answer any questions. V15 stated R1 not having a dressing in place is a nursing issue. V15 stated it would be expected for the facility to follow orders for wound care and dressings. V15 stated that V4 is qualified to take care of R1's wound. On 05/15/26 at 10:29 AM, V16 (Social Service Director/SSD/Transportation) stated she was made aware around 05/06/26 that R1 needed to see a wound specialist. V16 stated she called local wound specialists and R1 now has an appointment on 05/20/26. On 05/15/26 at 10:38 AM, V1 (Administrator) stated that R1's dressing should have been on, and there is no reason that the staff did not inform the nurses that it was off. V1 stated V4 (NP) should be looking at R1's wound every time she is at the facility but she is not sure that is happening. V1 stated V2 (RN/DON) will be getting wound certified to assist with wound care in the future. V1 stated she was not aware that R1 went three days after admission with no wound care orders. V1 stated she was not made aware of the issues with the lab/wound culture until 05/06/26 when they called to let the facility know they would need a new culture. V1 stated they are having issues with the lab company and are trying to use a company that is local. On 05/15/26 at 11:45 AM, V4 (NP) stated she is not sure why R1's wound would not have a dressing on it. When asked about R1 not consistently having a dressing on her wound and if that could cause the wound to deteriorate, V4 stated 7 hours without a dressing on a wound is better than having a wet (adult incontinence brief) on. V4 stated the wound should have a dressing on it. V4 stated she saw the wound on 05/13/2026 and she looks at it weekly. V4 stated she is not sure how much slough is in the wound but knows the wound had minimal drainage. V4 stated the slough is improving. V4 stated the treatment for a wound that is tunneling would be to pack the wound and V4 stated the facility is packing the wound. V4 stated the wound is getting treated with Medihoney and silver nitrate. V4 said she ordered a wound consult for R1 to see if the wound treatment needed changed so the wound can heal faster. V4 stated on admission, R1's wound should have been coded as a stage 4, the worst a wound can be staged. V4 stated she was not aware the culture that was ordered on 04/30/26 was not completed. V4 stated she knew the wound was infected by the smell and appearance which is why she ordered a culture. V4 stated not getting the results back until 05/13/26 did not delay the treatment of the wound. When asked why V4 believes the wound was improving, V4 said she was judging that by the measurements the facility has. V4 stated she does not know why one week the wound is documented as undermining of 2 cm and the next week there is no undermining. V4 stated she looked at R1's wound on 05/13/26 when staff were changing R1 but does not know the employee's name she went with. V4 stated that the wound looks much better than the day R1 was admitted . V4 stated again that the facility is using Medihoney and silver nitrate in the wound bed for packing purposes. The facility's Skin Identification, Evaluation and Monitoring policy with a date of February 2026 documented under Purpose - The purpose of this policy is to outline a method of identification, evaluation and monitoring for alterations in skin integrity. Communities will implement preventative measures, and an individualized care plan will be formulated upon completion of findings. Under the section titled Skin Integrity treatment program documents A. Eliminate or reduce the source of pressure using positioning techniques, enhancement of mobility and circulation, support of ancillary team members, b. other sources of skin injury by ev

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate pain assessment and pain relief medication for 1 (R1) of 3 residents reviewed for pain management in the sample of 4. This failure resulted in R1 feeling helpless and having uncontrolled pain which was worse during wound care treatments. The Findings Include:R1's admission Record documented admission to the facility on [DATE] and included diagnoses of heart failure, thrombocytopenia, depression, anxiety, obstructive sleep apnea, personal history of malignant neoplasm of thyroid, and lymphedema. R1's Care Plan includes a Focus area of the resident has actual impairment to the skin integrity related to coccyx pressure wound with an initial date of 05/13/2026. Corresponding interventions included to administer treatments as ordered, document wound size, and monitor dressing when providing care to ensure it is intact and adhering. Report loose dressing to nurse. The R1's Care Plan does not document a Focus area for pain management. R1's Minimum Data Set (MDS) assessment dated [DATE] is coded as an admission assessment and documents Brief Interview for Mental Status (BIMS) score of 07, indicating R1 has cognitive impairment. This MDS documents that R1 is occasionally incontinent of bowel and bladder and documents R1 has a stage 2 pressure ulcer. This MDS documents in section J0300 Pain Assessment Interview - Pain Presence - ask resident have you had pain or hurting any time in the last 5 days? This section is answered with a 0, indicating R1 has not had any pain. R1's Order Summary Report includes the following orders: - Acetaminophen Tablet 325 MG (milligrams) give 2 tablet by mouth every 4 hours as needed for Elevated Temp, Do not exceed 3GM acetaminophen from all sources in 24 hours, dated 4/13/26- Acetaminophen Tablet 325 MG (milligrams) give 2 tablet by mouth every 4 hours as needed for Mild Pain (1-4 on pain scale), Do not exceed 3GM acetaminophen from all sources in 24 hours, dated 4/13/26- Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 6 hours as needed for pain, dated 5/06/26- Ibuprofen Oral Tablet 600 MG (Ibuprofen) Give 600 mg by mouth every 6 hours as needed for pain to buttocks use between doses of hydrocodone for breakthrough pain, dated 5/13/26- Ibuprofen Oral Tablet 600 MG (Ibuprofen) Give 600 mg by mouth every 4 hours as needed for pain to buttocks use between doses of hydrocodone for breakthrough pain, dated 5/14/26- Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain, dated 5/14/26 There were no regularly scheduled or daily pain assessments found in R1's Electronic Medical Record (EMR) for review. R1's May 2026 Medication Administration Record (MAR) documented the following pain assessments along with administration of the following pain medications: 05/03/26: Pain level of 3 documented at 7:31AM with administration of Acetaminophen Tablet 325mg, give 2 tablets by mouth every 4 hours as needed for mild pain (1-4 on pain scale) with E documented for Effective. Pain level of 3 documented again at 4:48PM with administration of Acetaminophen Tablet 325mg, 2 tablets, with E documented for Effective. 05/07/26: Pain level of 7 documented at 5:04AM with administration of Acetaminophen Tablet 325mg, give 2 tablets by mouth every 4 hours as needed for mild pain (1-4 on pain scale) with E documented for Effective.05/07/26: Pain level of 6 documented at 9:43AM with administration of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth every 6 hours as needed for pain with E documented for Effective. 05/08/26: Pain level of 8 documented at 7:23PM with administration of Acetaminophen Tablet 325mg, give 2 tablets by mouth every 4 hours as needed for mild pain (1-4 on pain scale) with E documented for Effective.05/09/26: Pain level of 5 documented at 7:10AM and a pain level of 8 documented at 7:31PM both with administrations of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth with E documented for Effective. 05/10/26: Pain level of 5 documented at 7:17AM and again at 5:04PM, both with administrations of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth with E documented for Effective. 05/11/26: Pain level of 8 documented at 5:08AM and level of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0697 Level of Harm - Actual harm Residents Affected - Few	5 documented at 4:46PM, both with administrations of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth with E documented for Effective.05/12/26: Pain level of 6 documented at 8:08AM and again at 4:59PM, both with administrations of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth with E documented for Effective.05/13/26: Pain level of 5 documented at 5:35AM, level of 7 at 11:53AM, and level of 6 at 6:49PM, all with administrations of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth with E documented for Effective. 05/14/26: Pain level of 8 documented at 5:52AM, with administration of Hydrocodone-Acetaminophen Oral Tablet 5-325mg, 1 tablet by mouth with E documented for Effective. On 05/13/2026 at 10:42 AM, R2 stated she and R1 used to be roommates. R2 stated that R1 would cry out in pain when the staff would provide care for her wound. R2 was alert and oriented to person, place and time. On 05/13/2026 at 11:46 AM, R1 stated her wound to her butt hurts her really bad. R1 stated that the medication does not help with the pain. R1 said she feels helpless because her pain is so bad. R1 stated she is incontinent now and needs changed. R1 stated she tries to just sleep all day and night because her pain is so bad. R1 stated I am miserable this hurts so bad. R1 then attempted to sit and immediately laid back down saying she hurts too much. On 05/13/2026 at 11:50 AM, V3 (Registered Nurse/RN) stated R1 can have a pain pill, and he will give her one now. V3 stated he will ask if R1 can have ibuprofen in between times to help. On 05/13/2026 at 11:56 AM, V4 (Nurse Practitioner/NP) stated R1 was started on hydrocodone and it is managing her pain just fine. V4 stated R1 is being referred to wound care and she plans to order ibuprofen. On 05/14/2026 at 07:00 AM, R1 was alert to self and time. R1 recognized this surveyor from meeting the previous day. V8 (Certified Nurse Assistant/CNA) was providing incontinence care to R1 at this time and R1 knew V8 by name. R1 was observed to be tearful and crying out, stating she was hurting. On 05/14/2026 at 7:41 AM, V8 (CNA) stated R1 has been complaining of pain to her wound for a few weeks now. V8 stated she has reported this to nurses, and no one seems to be treating it. V8 stated R1 will cry out when providing care to her and say she hurts. On 05/14/2026 at 8:58 AM, V3 (Registered Nurse/RN) stated R1 often cries out and cannot relay to the staff what her concerns are. V3 stated that since the slough has come off R1's wound, she has been in more pain. V3 stated when he does the dressing change for R1, she moves around, squirming, flinching and complaining it hurts. V3 stated when he observed R1 complaining more of pain, that is why he requested the order for additional/stronger pain medications on 05/06/2026. On 05/14/2026 at 9:02 AM, V3 (RN) donned Personal Protective Equipment (PPE) and knocked on R1's door. V3 then explained to R1 that it was time to complete her dressing change. R1 was tearful and complained of pain at this time. V3 explained that it was not time for another pain medication pill, but he can call the doctor after they are finished to ask about changing the times. V3 provided incontinence care and wound care for R1 at this time. During the treatment, R1 was moaning, tearful and moving her legs. At one point, R1 let out a loud moan/cry and drew her legs up. On 05/14/2026 10:10 AM, V3 (RN) stated he called the nurse practitioner and received a new order to increase R1's pain medication to every 4 hours from every 6 hours. V3 stated he just gave R1 the medication. On 05/15/2026 at 9:05 AM, V13 (RN) stated when R1 was first admitted her wound was mostly slough and the Tylenol covered the pain she had. V13 stated once the slough started coming off and they realized there was tunneling, R1 has complained of more pain. On 05/15/2026 at 9:15 AM, V2 (Director of Nursing/DON/RN) stated when the nurse gives a pain medication, there is an alert created that the nurse has to go back and document whether the medication was effective or ineffective. V2 stated that documentation is the pain assessment that is completed when the resident asks for pain medication. V2 stated the facility does not do routine pain assessments on everyone. V2 stated she thinks there may be a few residents who have them. V2 stated that if a staff member observes a resident in pain and the pain is worsening, they should contact the doctor. V2 stated if a resident is complaining of hurting during a treatment, the nurse should provide medication prior to treatment to prevent pain or notify the physician to see if there is a change needed to the pain medication regimen. On 05/15/2026 at 10:38 AM, V1 (Administrator) stated there are times when R1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0697 Level of Harm - Actual harm Residents Affected - Few	does cry out even when not receiving care. V1 stated she expects staff to rule out all causes of the crying and just not assume it's behavioral. V1 stated there are times R1 can tell you what is hurting and other times R1 states the word hurt and can't say where. On 05/15/2026 at 11:45 AM, V4 (Nurse Practitioner) stated when she is in the facility, she looks at R1. V4 stated that when R1 is given a pain medication she seems to be comfortably resting after it is given, and that is why she felt R1's pain was controlled. V4 said she gave an order for ibuprofen to help with the breakthrough pain. V4 stated she also evaluates the pain medication effectiveness by the nurse's documentation. V4 stated the nurses have documented that V4's pain is controlled. The facility's policy titled Pain Management with a date of 02/2025 documented It is the policy of this facility to respect and support the resident's right to optimal pain assessment and management. This facility recognizes that residents may have decreased sensations or perceptions of pain. Optimal management of the resident experiencing pain enhances the healing and promotes both physical and psychological wellness.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection prevention practices, including Enhanced Barrier Precautions were implemented for 1 (R1) of 3 residents reviewed for infection control in the sample of 4.The Findings Include:R1's admission Record documented an admission date of 04/10/2026 and included diagnoses of heart failure, thrombocytopenia, depression, anxiety, obstructive sleep apnea, personal history of malignant neoplasm of thyroid, and lymphedema.R1's Minimum Data Set (Minimum Data Set) assessment dated [DATE] and coded as an admission assessment documents a Brief Interview for Mental Status (BIMS) score of 07, indicating R1 has severe cognitive impairment. The same MDS documents R1 is occasionally incontinent of bowel and bladder and further documents R1 has a stage 2 pressure ulcer.R1's Order Summary Report documents an active order dated 4/13/26 for ENHANCED BARRIER PRECAUTIONS: (wounds) with dressing, bathing, transfers, changing linens, providing hygiene, toileting or pericare, device care, or wound care every shift. R1's Care Plan documents no Focus areas or interventions related to Enhanced Barrier Precautions prior to 5/13/26.R1's Care Plan documents an added Focus area of the resident has actual impairment to skin integrity related to buttock and coccyx pressure wound (initiated 05/13/2026). Corresponding interventions include: wound culture results came in with ESBL (Extended-Spectrum Beta-Lactamase)/ECOLI (Escherichia coli) (initiated on 05/13/26). R1's Care Plan also documents a Focus area added of the resident is on enhanced barrier precautions (EBP) related to pressure wound (initiated 05/13/2026). Corresponding interventions include: Direct care staff and visitors to follow EBP, direct care staff to utilize gowns and gloves for all personal care, educate resident, responsible party, and direct care staff on EBP, monitor resident for signs and symptoms of infection. Document and properly report signs/symptoms of potential infections, monitor residents psychosocial and mental well-being related to EBP. Document any changes and report any symptoms promptly, and provide support and allow resident to express feeling, fears, and concerns. All interventions for this focus area were documented to be initiated on 05/13/2026. On 05/13/2026 at 8:30 AM during a tour of the facility, R1's room was observed to not have any signage indicating R1 was on isolation. R1's room did not have a Personal Protective Equipment (PPE) station outside of the room.On 05/13/2026 at 8:52 AM, V8 (Certified Nurse Assistant/CNA) was observed caring for R1 and stated she was completing a bed bath. V8 did not have PPE on at this time. On 05/14/2026 at 5:05 AM, V5 (Licensed Practical Nurse/LPN) stated R1 was moved to a room last night because she had to be put on isolation precautions for an infection in her wound. V5 stated she was not sure if R1 was on enhanced barrier precautions.On 05/14/2026 at 5:50 AM, V7 (CNA) was observed walking into R1's room. V7 uncovered R1 and looked at her adult incontinence brief. V7 did not have PPE on at this time.On 05/14/2026 at 6:00 AM, V7 stated she was supposed to wear a gown when she went into R1's room but didn't. V7 stated she wasn't sure why she did not wear a gown but knows that R1 is on isolation.On 05/14/2026 at 07:00 AM, V8 (CNA) donned PPE and entered R1's room. V8 opened a pack of incontinence wipes, folded down R1's incontinence brief, used the wipe to clean the left side of R1's peri area, and discarded the wipe. With the same gloves on, V8 pulled another wipe from the package and wiped the right side of the peri area and discarded the wipe. V8 pulled another wipe from the package and wiped down the middle of R1's peri area. V8 then rolled R1 over to her right side, grabbed another wet wipe from the package, and began wiping R1's coccyx area, which was soiled with stool. V8 discarded the wipe and pulled another one from the package using the same gloves. V8 cleaned R1's coccyx area that was soiled with stool, removed the soiled incontinence brief from R1's bed and threw it in the trash. V8 then discarded her gloves and applied new ones without performing hand hygiene. V8 placed a new brief on R1, then assisted R1 with dressing and assisted her to her wheelchair. V8 then disposed of her gloves and sanitized her hands. On 05/14/2026 at 7:41 AM, V8 (CNA) stated R1 was not on isolation precautions of any kind on 05/13/2026. V8 stated R1 was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146131	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cisne Rehabilitation and Health Care 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed on precautions last night after a wound culture came back.On 05/14/2026 at 7:43 AM, V9 (CNA) stated R1 was not on isolation yesterday. V9 stated R1 is on it today because of her wound culture.On 05/14/2026 at 8:56 AM, V1 (Administrator) stated she was not sure if R1 was on Enhanced Barrier Precautions or not. V1 stated she would ask V2 (Registered Nurse/RN - Director of Nursing/DON) when she gets here.On 05/14/2026 at 8:58 AM, V3 (Registered Nurse/RN) stated R1 was not on Enhanced Barrier Precautions yesterday. V3 stated when R1's culture was faxed yesterday to the facility, R1 was moved to an isolation room. V3 stated R1 should have been on Enhanced Barrier Precautions for her wound.On 05/14/2026 at 11:48 AM, V2 (DON) stated R1 should have been on Enhanced Barrier Precautions related to her wound. V2 stated she thought R1 was on these precautions. V2 said for residents who meet criteria, it would be her expectation that they be on Enhanced Barrier Precautions. V2 stated there should have been signs on the door notifying staff about isolation.On 05/14/2026 at 9:30 AM, V2 (DON) stated the facility does not have a policy on perineal care. V1 stated the facility just uses the checklist for a procedure guide for performing perineal care. V2 stated she expects staff to follow the checklist on providing care.A facility form titled Skills Checklist perineal care female documented staff should remove gloves, wash hands and apply clean gloves and apply clean brief or preferred underclothes.The facility policy titled Infection Prevention and Control Manual-Enhanced Barrier Precautions with no date documented Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk for MDRO acquisition (such as residents that have wounds or indwelling medical devices). This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and may residents colonized with a MDRO are asymptomatic or not presently known to be colonized.